Hoosier Healthwise MCO Reporting Manual
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A. Overview of Reporting Manual

This manual provides information for all performance reporting required by the Indiana Office of Medicaid Policy and Planning (OMPP) for Hoosier Healthwise managed care organizations (MCOs). This manual is organized in the following manner:

- Section I: General Reporting Overview briefly introduces the reporting process, describes submission requirements and provides contact information for questions or issues related to performance reporting.

- Section II: Report Index contains a list of all reports by category (e.g., systems and claims, member services, provider services, etc.), a reference resource for each report to the MCO's Contract, Scope of Work Attachment and report submission frequency.

- Section III: Report Descriptions and Templates gives specific descriptions and data templates, when required, for each report. This section provides instructions for completing each template, performance measures and data element definitions, as well as Excel database user instructions and the Report Submission Attestation document.

- Section IV: Report Submission Calendar identifies the dates the MCO must submit each performance report to OMPP and its monitoring contractor by month from January 2006 through May 2007.

B. Reporting Formats

The MCO must submit all performance data using the formats specified by OMPP and detailed in the performance reporting descriptions in Section III of this manual. The State's monitoring contractor, Navigant Consulting, Inc. (NCI), has prepared reporting templates and formats for each report that the MCO must use in submitting its performance data. If OMPP changes the reporting templates or formats, NCI will provide the MCO with new electronic versions of the templates or formats with a new version number. There are currently three formats for the performance reports:

1. Excel Database: The MCO must submit some performance data using Excel templates that NCI has formatted to be placed into a Reporting Database. These Excel templates include fields that contain drop down menu boxes for selecting performance data options. NCI has protected the Excel templates so the data entered by the MCO can populate OMPP's database and automate feedback reporting graphics. OMPP and NCI supply these templates electronically to the MCO.

2. Excel Templates: The MCO must submit some performance data using Excel templates that will not supply data into the automated database as described above. These reports may offer data description "code sheets" from which the MCO must select its performance data options. NCI has not protected these Excel templates from user's change. However, OMPP requires that the MCO submit its data in these templates without changing the template format. OMPP and NCI supply these templates electronically to the MCO.

3. Word Documents: The MCO must submit some performance data using word templates. NCI has not protected these word templates from user's change. However, unless otherwise noted in the report description, OMPP requires that the MCO submit its performance data in the template without modifying the template format.

C. Report Numbering Methodology

The report numbering provides insight to the content of the report by designating both the frequency and category of the report. The descriptions below provide an explanation of report numbering methodology.

- Frequency Indicator: The report number begins with a frequency indicator which is a two-letter designation as outlined below:

  AN – Indicates the report is an annual report
  QR – Indicates the report is a quarterly report
  SA – Indicates the report is a semi-annual report
  MO – Indicates the report is a monthly report

- Standard Category Indicator: Most report numbers follow the frequency indicator with a one letter category indicator as outlined below:

  S – Systems/Claims
  M – Member
  N – Network
  P – Provider
  Q – Quality
  F – Finance

- Other Category Indicators: Some reports have a non-standard category indicator. These reports are as follows:

  CRCS – Capitation Rate Calculation Sheet
  PIP – Provider Incentive Plan
  DUR – Drug Utilization Review
  FQHC – Federally Qualified Health Centers
  IDOI – Department of Insurance Filing

- Report Number: The last part of the report number is a numeral to differentiate the reports with the same category and frequency, for example:

  AN – Q3 = Annual Quality Report #3
  QR – F1 = Quarterly Financial Report #1

Additionally, some report numbering includes indicators to specifically identify the reporting data that should be contained in the template. For instance, the CRCS templates are named to indicate specific combinations for benefit packages, regions and rate categories, the templates for monthly data contain the name of the month in the template name, and the FQHC reports permit the MCO to enter the provider name into the template name. The reporting descriptions for the CRCS, FQHC, Member and Provider Helplines, Member Grievance and Member Appeals reports in Section III of this manual contain additional information about this type of template numbering.

D. Reporting Submission Requirements

The MCO must submit performance reports by the dates due as indicated in the report descriptions and in the specified formats. The Report Index (Section II) and the Report Submission Calendar (Section IV) provide information on dates due for the performance reports. OMPP has adjusted some reporting times (i.e., number of calendar days) in some reporting cycles to bring some consistency to the dates due for that cycle. If the MCO submits data with incorrect file or worksheet names, or in formats that have been altered in any other way except to provide the performance data for the current reporting period, OMPP will require the MCO to re-submit the data under correct file or worksheet names and in correct formats.

In all cases, the following requirements apply to performance reporting data submissions:

1. The MCO must submit all performance reporting data electronically (i.e., not in protected document format [pdf]) unless otherwise indicated in the individual report description or approved by OMPP prior to submission.

2. The MCO must submit all performance reporting data with the same file names provided in the electronic files (i.e., compact discs [CDs]) that NCI supplies to the MCO, unless otherwise indicated in the individual report description or approved by OMPP prior to submission.

3. The MCO must submit all performance reporting data with the same worksheet names as those provided in the electronic files (i.e., CDs) that NCI supplies to the MCO.

4. The MCO must submit all performance reporting data on time, accurately and under the MCO's executive's signature by completing the Report Submission Attestation document included in Section III of this manual. The MCO must have one MCO executive leader (i.e., financial officer, executive director, chief executive officer, president, etc.) sign the Report Submission Attestation document and electronically transmit the document in protected document format (pdf) or send the signed document via facsimile (FAX) to OMPP and the monitoring contractor with each data submission.

5. The MCO must submit all performance reporting data to OMPP and NCI using the following e-mail addresses:

   - hoosierdata@navigantconsulting.com
   - managedcare@fssa.in.gov

6. The MCO may submit performance data earlier than the actual date the data is due. However, OMPP will consider the MCO's performance data late if OMPP and NCI do not receive the performance data electronically in the designated e-mailboxes by 4:00 PM (Indiana time) on the date due.

7. The MCO may encounter internal operational issues that occasionally may prevent timely submissions of it performance data. OMPP will consider the MCO's request for an extension of the dates due for performance data under the conditions described below. OMPP will respond to the MCO's request via e-mail and will notify NCI of its decision to approve or deny the request. OMPP may consider the MCO's performance data submission as untimely if the MCO does not submit an extension request as follows:

   - The MCO must submit its request for an extension at least one full business day before the data is due to OMPP and NCI.

   - The MCO should submit the request in writing via e-mail directly to the plan's assigned OMPP Policy Analyst and copying Ginger Brophy at OMPP.

- The MCO's written request must be sent from the MCO's Compliance Officer or his/her alternate.

- The MCO's written request must explain why the MCO is requesting an extension and must suggest another submission due date for OMPP to consider.

8. If the MCO has identified specific operational issues that positively or negatively impacted its performance during the reporting cycle, OMPP encourages the MCO to explain such as supplemental comments. There are two ways the MCO can add comments to its performance data submissions: comments fields and submission e-mail messages. The User Guidelines in Section III of this manual explain each way the MCO can submit comments.

9. The MCO must submit complete and accurate data. However, if the MCO discovers that it has omitted some performance data during a reporting cycle or if the MCO discovers errors in data submitted to OMPP and NCI, the MCO must notify its designated OMPP Policy Analyst upon discovery. The OMPP Policy Analyst will confer with NCI and instruct the MCO as to how to submit this data. When the MCO receives instructions to submit missing data or submit corrected data, the MCO must submit the data electronically to the e-mail addresses identified above (see item 5) and must transmit its data with an e-mail message indicating:

    - The data submission as "REPLACEMENT"
    - The name of the reports being submitted
    - The reporting period to which the data applies

    Unless otherwise noted, OMPP and NCI will consider the initial set of replacement data for omissions or inaccuracies as final and will base its feedback comments on that data. If OMPP and NCI receive the MCO's replacement data within ten (10) business days from the original date due, OMPP and NCI will incorporate the data into the current reporting cycle feedback. If OMPP and NCI receive the MCO's replacement data beyond ten (10) business days from the original date due, OMPP and NCI will incorporate the replacement data into the next reporting cycle feedback.

OMPP may consider the MCO's performance data as not received, not received on time or inaccurate if performance data is submitted in templates or formats not approved by OMPP, or with inaccurately named electronic files or worksheets, or submitted to any other contact e-mail addresses than the two indicated above (see item 5). If the MCO fails to provide performance data as required, OMPP may consider the MCO non-compliant in its

performance reporting and may assess liquidated damages or other remedies as described in the MCO Contract, Scope of Work Attachment, Section 8.

E. Performance Reporting Feedback

OMPP will provide feedback to the MCO regarding its performance reporting data. Feedback may include confirmation letters upon receiving the performance data, feedback reports itemizing issues for which OMPP requires additional explanation, and graphics displaying the MCO's performance, compared to performance standards, national benchmarks, or other participating MCOs' performance, as appropriate. In addition to regular feedback reports, OMPP meets with the MCO's Chief Executive annually to discuss the Hoosier Healthwise program and review the MCO's performance and reporting data.

OMPP, or NCI on OMPP's behalf, may schedule meetings or conference calls with the MCO upon receiving the MCO's performance data or distributing feedback reports. When OMPP identifies issues, the MCO must formally respond in writing to these issues within five (5) business days of the receipt of the feedback report, or the feedback meeting or conference call, whichever is later. If the MCO fails to provide a formal, written response to the feedback or fails to respond within five (5) business days, OMPP may consider the MCO non-compliant in its performance reporting and may implement corrective actions.

F. Contact Information

The MCO's Compliance Officer will be responsible for submitting its performance reporting data and receiving confirmation and feedback from OMPP. This liaison will be responsible for distributing OMPP's feedback within the MCO's organization and coordinating with OMPP or NCI to schedule feedback meetings or conference calls. However, OMPP recognizes that there may be occasions when a Compliance Officer is not available to facilitate, oversee or communicate with OMPP or NCI directly. OMPP encourages each MCO to designate an alternate for its Compliance Officer. The Compliance Officer should contact the plan's OMPP Policy Analyst with his/her alternate's contact information. OMPP and NCI will then recognize either person as the authorized persons to transmit and submit the plan's performance data to OMPP and NCI, or to communicate or request information related to the plan's performance data.

For questions or issues related to the reporting requirements, data elements definitions, due dates, report content or the reporting database for the Hoosier Healthwise managed care program, the MCO is encouraged to contact:

- The OMPP Policy Analyst assigned to the MCO; or,
- NCI's designated contact person for performance reporting issues:

Charren L. Nelson, Managing Consultant
Navigant Consulting, Inc.
1801 K Street, NW
Suite 500
Washington, DC 20006
Telephone: 202-973-3135
FAX: 202-973-2401
e-mail: cnelson@navigantconsulting.com

Item No.	Report No.	Name of Report	MCO Contract Scope of Work Reference	Report Frequency	Template Type
Systems and Claims Reports					
1	QR-S1	Claims Processing Summary	Attachment 1: Section 6.4	Last day of the month following the end of the reporting calendar quarter	Database
2	QR-S2	Adjudicated Claims Inventory Summary	Attachment 1: Section 6.4	Last day of the month following the end of the reporting calendar quarter	Database
3	QR-S3	Top Ten Claims Denial Reasons	Attachment 1: Section 6.4	Last day of the month following the end of the reporting calendar quarter	Database
Member Services Reports					
4	MO-M1	Member Helpline Performance	Attachment 1: Section 3.1	15th day of the month following the reporting calendar month; or, Last day of the month following the end of the reporting calendar quarter at OMPP's discretion	Database
5	MO-M2	Member Grievances	Attachment 1: Section 3.5	15th day of the month following the reporting calendar month; or, Last day of the month following the end of the reporting calendar quarter at OMPP's discretion	Database
6	MO-M3	Member Appeals	Attachment 1: Section 3.5	15th day of the month following the reporting calendar month; or, Last day of the month following the end of the reporting calendar quarter at OMPP's discretion	Database
7	QR-M1	FSSA Hearings and Appeals	Attachment 1: Section 3.5	Ad Hoc Report that is due the last day of the month following the end of the reporting calendar quarter after initial OMPP notification until resolution is reported	Excel
8	AN-M1	Summary of Consumer Assessment of Health Plan Survey (CAHPS®) Summary	Attachment 1: Section 5.1	Last day of the month following the end of the second quarter	CAHPS

Item No.	Report No.	Name of Report	MCO Contract Scope of Work Reference	Report Frequency	Template Type
Network Development and Access Reports					
9	QR-N1	Promotional, Educational, Outreach and Incentive Materials Inventory and Distribution	Attachment 1: Section 3.2 Attachment 1: Section 4.6	For review during OMPP on-site visits	MCO Choice
10	AN-N1	Network Geographic Access Assessment	Attachment 1: Section 4.2	January 31st	MCO
11	AN-N2	Provider Directory	Attachment 1: Section 4.12	January 31st	Excel
12	AN-N3	Subcontractor Compliance Summary Report	Attachment 1: Section 1.6	For review during OMPP on-site visits	MCO Choice
13	AN-N4	24 Hour Availability Audit	Attachment 1: Section 4.2	Last day of the month following the end of the fourth calendar quarter	Excel
Provider Services Reports					
14	MO-P1	Provider Helpline Performance	Attachment 1: Section 4.7	15th day of the month following the reporting calendar month; or, Last day of the month following the end of the reporting calendar quarter at OMPP's discretion	Database
15	QR-P1	Informal Provider Claims Disputes	Attachment 1: Section 4.10	Last day of the month following the end of the reporting calendar quarter	Database
16	QR-P2	Formal Provider Claims Disputes	Attachment 1: Section 4.10	Last day of the month following the end of the reporting calendar quarter	Database
17	QR-P3	Binding Arbitration	Attachment 1: Section 4.10	Ad Hoc Report that is due the last day of the month following the end of the reporting calendar quarter when the MCO has received a Binding Arbitration request	Database

Item No.	Report No.	Name of Report	MCO Contract Scope of Work Reference	Report Frequency	Template Type
Quality Management and Improvement Reports					
18	QR-Q1	Quality Management and Improvement Committee Meeting minutes	Attachment 1: Section 5.1	For review during OMPP on-site visits	MCO Choice
19	QR-Q2	Medical Necessity Review Log	Attachment 1: Section 5.2	For review during OMPP on-site visits	MCO Choice
20	AN-Q1	Quality Management and Improvement Work Plan	Attachment 1: Section 5.1	March 1st and updated at OMPP's request	Word
21	AN-Q2	HEDIS® Data Submission Tool (DST)	Attachment 1: Section 5.0	June 15th per NCQA schedule	HEDIS
22	AN-Q3	HEDIS® Baseline Assessment Tool (BAT)	Attachment 1: Section 5.0	Last day of the month following the fourth calendar quarter or per NCQA schedule	HEDIS
23	AN-Q4	HEDIS® Compliance Auditor's Final	Attachment 1: Section 5.0	August 1st per NCQA schedule	HEDIS
24	AN-Q5	Asthma Common Measures	Attachment 1: Section 2.8	Per schedule	Excel MCO Choice
Utilization Reports					
25	SA-CRCS-1	Capitation Rate Calculation Sheet	Attachment 1: Section 1.5	135 calendar days after the last day of the second and fourth calendar quarters	Database
26	SA-CRCS-2	Maternity Capitation Rate Calculation Sheet	Attachment 1: Section 1.5	135 calendar days after the last day of the second and fourth calendar quarters	Database
Financial Reports					
27	QR-F1	Indicators of Financial Stability	Attachment 1: Section 6.6	45 calendar days after the last day of the reporting calendar quarter, except for the fourth quarter reports, which is due March 1st	Database
28	QR-IDOI	Indiana Department of Insurance (IDOI) Filing	Attachment 1: Section 1.5	45 calendar days after the last day of the reporting calendar quarter, except for the fourth quarter reports, which is due March 1st	IDOI
29	SA-F1	Stop Loss	Attachment 1: Section 1.5	135 calendar days after the last day of the second and fourth calendar quarters	Database
30	AN-PIP	Physician Incentive Plan	Attachment 1: Section 4.11	January 31st for OMPP's review during on-site visits	CMS
31	AN-F1	Insurance Premium Notice	Attachment 1: Section 1.5	For review during OMPP on-site visits	MCO Choice
32	AN-FQHC	Reimbursement for FQHC and RHC Services	Attachment 1: Section 4.2	45 calendar days after the second calendar quarter	Excel

Item No.	Report No.	Name of Report	MCO Contract Scope of Work Reference	Report Frequency	Template Type
Annual Single Source Prior Authorization Drug Listing Reports					
33	AN-DUR-1	PDL Comparison of Select Therapeutic Classes, Open Access With No	Attachment 1: Section 1.4	March 1st	Excel
34	AN-DUR-2	PDL Comparison of Select Therapeutic Classes, Clinical Edits With Rationale	Attachment 1: Section 1.4	March 1st	Excel
35	AN-DUR-3	Number of Prior Authorizations By Drug	Attachment 1: Section 1.4	March 1st	Excel
36	AN-DUR-4	Pharmacy Prior Authorizations	Attachment 1: Section 1.4	March 1st	Excel
37	AN-DUR-5	Pharmacy-related Grievances	Attachment 1: Section 1.4	March 1st	Excel

Introduction

The Hoosier Healthwise MCO must submit its performance data using the Word and Excel templates OMPP is providing in this section. The MCO must use all the provided templates to submit performance data for the required reports. For some of the reports, OMPP has developed an Excel Database to manage data entry and assist with data analysis. OMPP is including the following guidelines to facilitate the use of the new Excel Database. **If at anytime the MCO has difficulty entering data into any template, please FIRST review these User Guidelines and the Reporting Instructions for each template carefully for resolutions to any problems. If neither the User Guidelines nor the Reporting Instructions address the MCO's problems, the MCO should contact the plan's OMPP Policy Analyst.**

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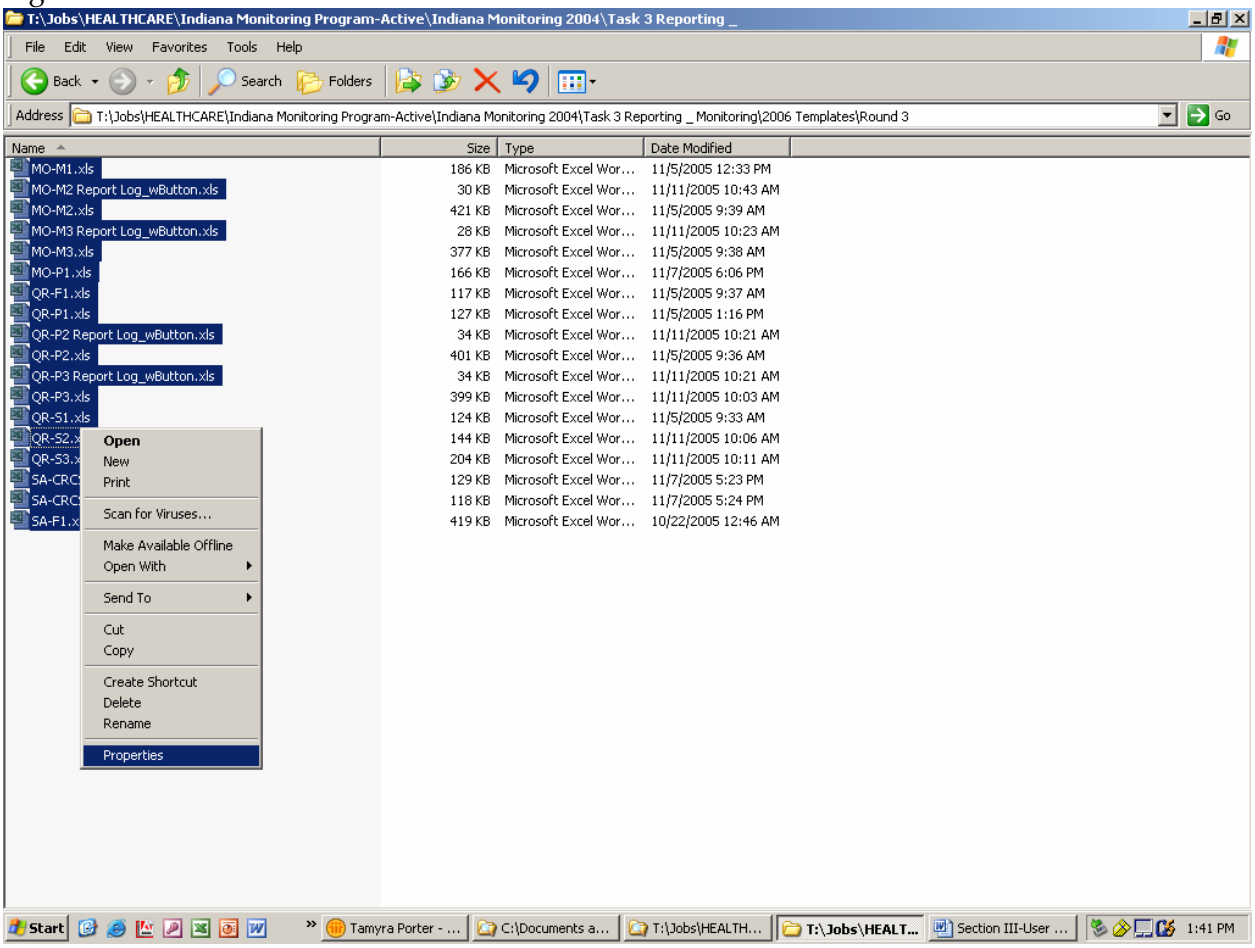
Using the Excel Database Files

OMPP provides the Hoosier Healthwise MCO Reporting Manual on a compact disc (CD) that contains ***all*** the reporting templates, i.e., Word template documents, Excel templates and those designated as Excel Database templates. The MCO should save an original copy of the Excel Database templates onto its computer system as master documents. After saving the files to the MCO's computer system, the MCO must deselect the Read Only file Properties. To do so, first select all the files by pressing the Ctrl and A key on the keyboard. Then, right click on the shaded area of the selected files and select "Properties" as outlined in Figure 3.1.

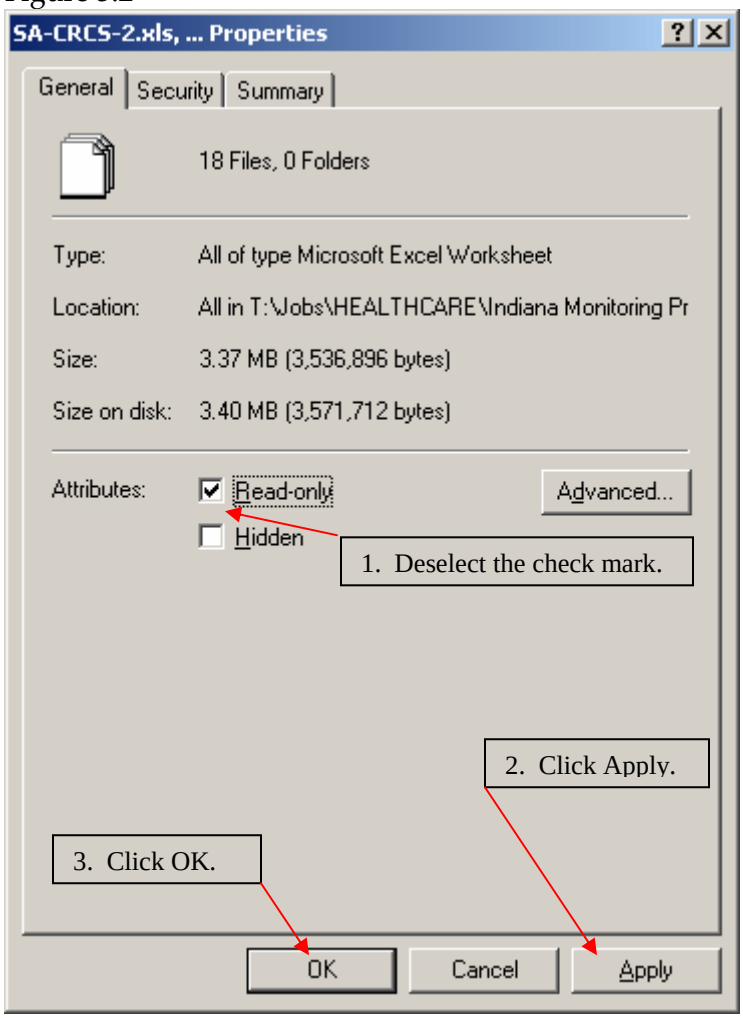
Figure 3.1



[The remainder of this page has been intentionally left blank.]

Within the General Tab of the Properties Screen as illustrated in Figure 3.2, allows users to change the Attributes of the Files to Read Only. To de-select the Read Only attribute, click on the check mark, choose Apply and then Close.

Figure 3.2



The MCO must use a new copy of the Excel Database templates found on the CD, and saved as master documents, as a starting point for each data submission. With the exception of four reports discussed below, the MCO should not begin subsequent data submissions using a previously-submitted Excel Database template as a starting point. The Member Grievances (MO-M2), Member Appeals (MO-M3), Provider Formal Claims Disputes (QR-P2) and the Binding Arbitration (QR-P3) reports include a report log. The MCO must use the report log for each of these reports from one reporting period to the next, supplementing previously-submitted information with the current reporting period's information.

Changing or Renaming Excel Database Files

The MCO must not change the Excel Database file names. The Excel Database is programmed to recognize the files as named in order to automate uploading the MCO's data. Changing or renaming the files will prevent the data from being entered into the Excel Database. If the MCO wishes to save its data submissions, and since computer systems will not allow saving files with the same names within the same directory without overriding previously entered data, the MCO should create a folder named for each reporting period and save the files for that reporting period in that folder. (Note: Computer systems will permit saving like-named files in differently-named folders.) In cases where OMPP is permitting the MCO to report monthly data on a quarterly basis (e.g., Member Helpline Performance (MO-M1) report), OMPP is providing an Excel Database template for each month, named appropriately for the month, to allow saving three month's reports in one folder.

Layout of the Excel Database Template Files

Each of the Excel Database template files contains three worksheets: Data, Template, and Code Descriptions. **The Data worksheet is the only worksheet for data entry.** OMPP is providing the Template and the Code Description worksheet for informational and reference purposes only.

Excel Database Template File Types

The Excel Database template files are either fixed or multi-line files. Figure 3.3 (below) identifies each report, by its report number, contained in the Excel Database and outlines how each report is classified (i.e., fixed, multi-line, or both).

Figure 3.3

Report Type	Reports
Fixed	MO-M1, MO-M2, MO-M3, MO-P1, SA-CRCS-1, SA-CRCS-2, QR-F1, QR-P1, QR-P2, QR-P3, QR-S1, QR-S2, QR-S3
Multi-Line	SA-F1

Fixed reports request specific measures and allow the MCO's user to enter the data directly into the template.

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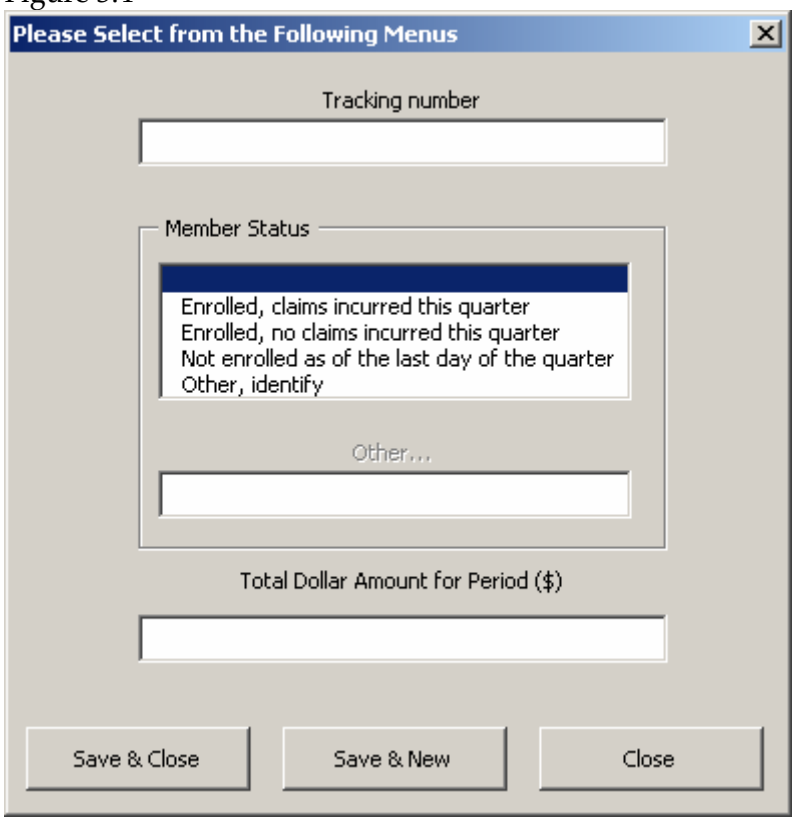
Multi-line reports require the MCO's user to click on an "Insert Item", "Change Item", or "Delete Item" button to enter or edit multiple lines of similar data. A pop-up form containing data fields that are specific to each report will appear when clicking on these buttons. Figure 3.4 (below) contains an example of the pop-up window for the Stop Loss (SA-F1) report.

Figure 3.4



The MCO must use the pop-up form to enter its performance data. The MCO's user can exit the pop-up form using one of the following three options:

- Save & Close – Closes the pop-up form and returns the MCO's user to the worksheet. MCO's users will see the data information entries populated within the worksheet area, but will not be able to edit data information directly in the worksheet. To edit existing data information entries, the MCO's users must click on the "Change Item" button.

- Save & New – Saves the current entries behind the pop-up form in the Excel worksheet and refreshes the data entry form to allow entry of additional data. NOTE: If the MCO's user accesses the pop-up form after selecting "Change Item", this feature will not appear.

- Close – Closes the pop-up form and returns the MCO's user to the worksheet without saving any data that the user may have been entered.

Protection for the Excel Database Files

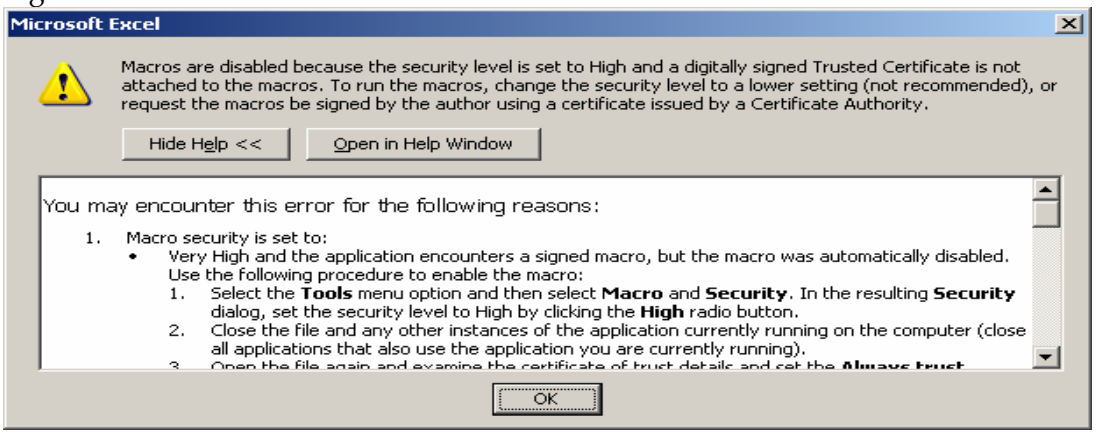
The pop-up forms and other menu selection options, force data entry consistency among all MCO users, resulting in more accurate data submissions. OMPP has protected the Excel Database templates to prevent MCO's from inadvertently changing the templates. The MCO's users must never unprotect the template to **write in options or information that is not provided in the menu selections.** Unprotecting the templates at any time will negate formulas and programming embedded in the template and will prevent the MCO's data from being uploaded into the Excel Database. If the menu options do not meet the MCO's needs, all menu selections include an "Other, identify" option. When the MCO selects this option, the template will allow the MCO to enter a brief descriptive text as an option that is not shown in the menu selections. OMPP will review these "Other, identify" descriptions to modify the menu selections as it deems appropriate.

The columns in the Excel Database templates have been pre-set. Occasionally, the column widths will not accommodate displaying all the data the MCO's user is entering. When this occurs, the template cell will display "#" in that cell. However, the MCO's data has actually been captured and will be visible in the formula box at the top of the Excel template. The MCO's user should confirm that the data displayed in the formula box is correct, and after completing data entry in other fields on the template, save the data.

Security Settings

The Excel Database templates contain programming to enhance the accuracy of reported data. In order for the MCO's computer to recognize the programming, the MCO's users **may need to set the macro security settings to "Medium" or "Low" within Microsoft Excel**. If the macro security setting is not set to "Medium" or "Low", a message similar to the one displayed in Figure 3.5 below may appear upon entering a Database template. *Please note, this message may vary slightly.*

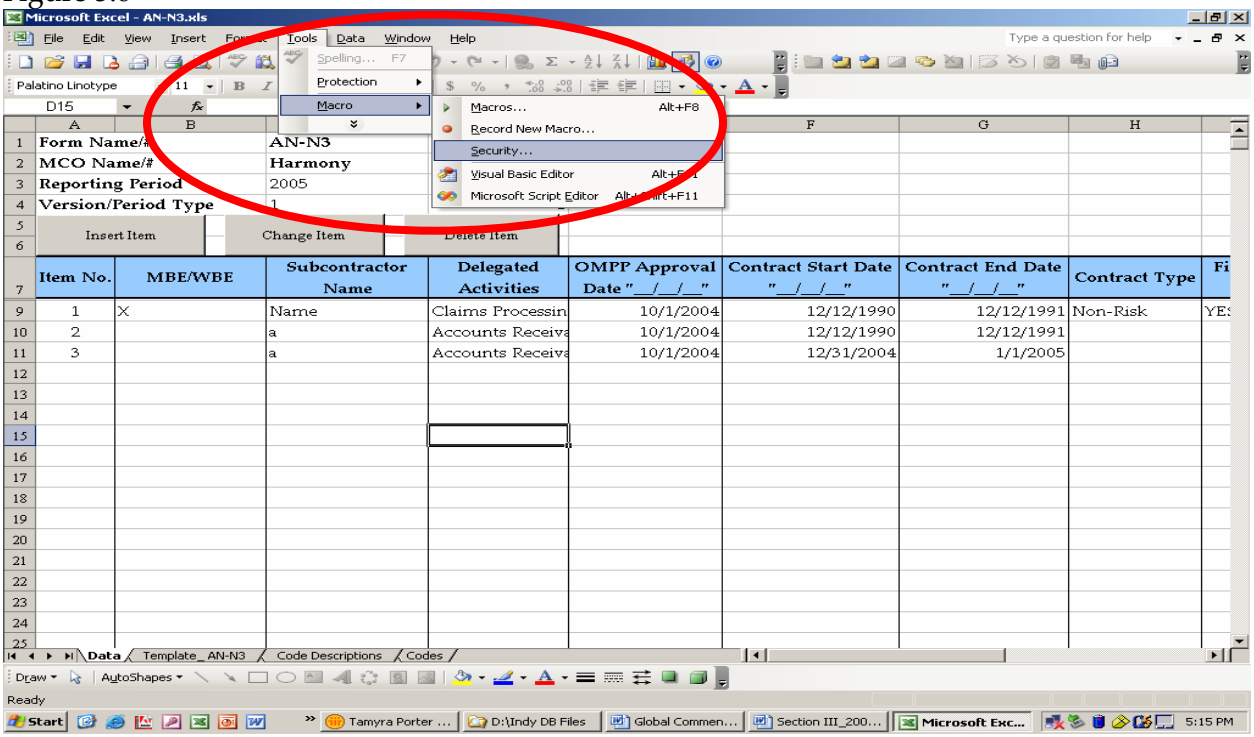
Figure 3.5



Modifying the security settings on the MCO's user's computer system should not impact the use of other programs on the user's system. Additionally, if the message (above) does not appear, the templates should run without having to modify the security level of the macros. To modify the security settings, the MCO's users should follow the steps outlined below:

1. Click on Tools from the Excel tabs located at the top of the screen as illustrated in Figure 3.6.
2. Move the cursor over the macro option.
3. Select Securities from the macro options appearing on the right.

Figure 3.6



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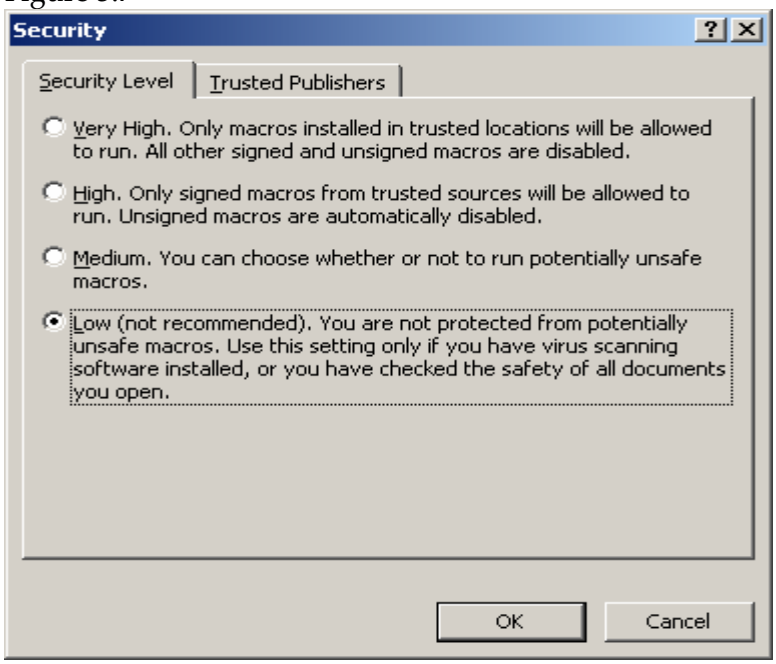
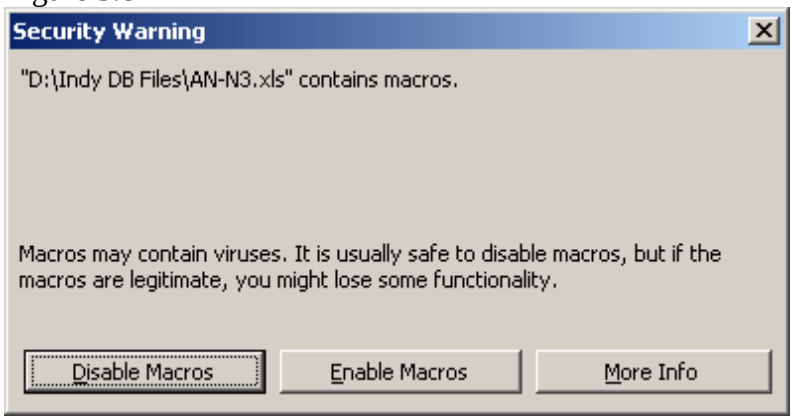
4. Click on "Medium" or "Low" to enable the macros and programming, as illustrated in Figure 3.7. OMPP recommends using the "Low" setting.

Figure 3.7



NOTE: Choosing a "Medium" setting will activate the prompt below (Figure 3.8) when opening any files that contain macros. This message will not appear if "Low" is chosen.

Figure 3.8

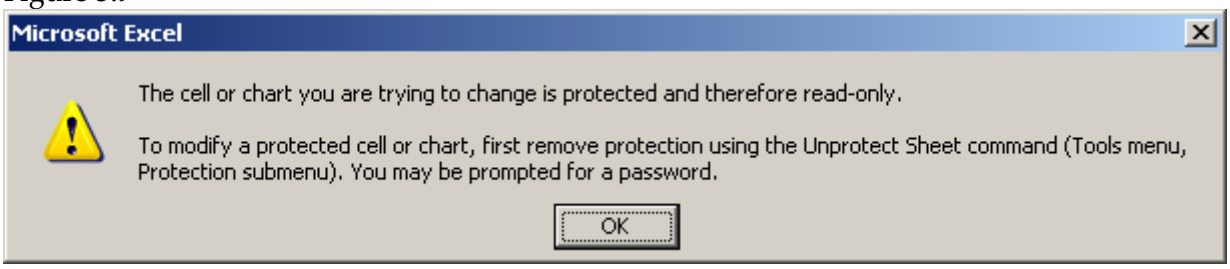


5. Click on the OK button and continue to exit the Excel file.
6. Re-open the Excel file after saving all the settings.

Locked Cells

The database template files contain programming to ensure that the MCO enters data in the appropriate cells. **Do not edit or enter data into locked cells.** If the MCO attempts to edit or enter data in a locked cell, the message in Figure 3.9 will appear:

Figure 3.9

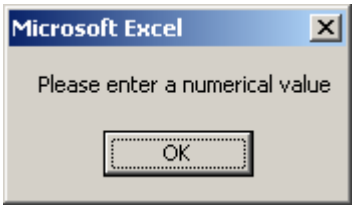


This message will also appear if the MCO's user attempts to edit data directly in a multi-line report without using the "Change Item" button.

To exit this message (Figure 3.9), click on the "OK" button and either move the cursor to an appropriate cell for data entry or click on the "Insert", "Change" or "Delete" Item buttons to complete the report. Note that data entry areas are clearly marked. OMPP is providing these messages to prevent inappropriate capture and use of submitted data.

Format Controls

Many of the Excel Database template files contain programming to ensure collecting data in an appropriate format. For example, entering "three" versus "3" for a numeric field will activate the following message.



Prompts will automatically appear throughout the Excel Database template files to improve the quality of data submission. Each of these messages will have an "OK" button for MCO's users to use to exit the message and enter the appropriate information. Unprotecting the worksheet will override the format controls and may result in inaccurate representation of the MCO's data.

Logic Controls

Many of the Excel Database files contain logic controls to prevent illogical entry. For example, entering an end date that is prior to a start date activates a prompt to enter an appropriate end date. OMPP has programmed the Excel Database templates to prompt the

MCO's user automatically as appropriate. The MCO's users must select the "OK" button to exit the prompt and correct the data entry.

Reporting No Data

When the MCO does not have data to report, OMPP offers the MCO two options:

1. OMPP encourages the MCO to insert zeros ("0") into all numeric fields for fixed reports and select "Other, identify" in multi-line reports, entering in "No data to report".

2. The MCO's users may submit a blank template with the reporting period identified, by using the drop down options located at the top of the template. The MCO's users must indicate in the submission e-mail or on the Attestation Sheet that must accompany all data submissions, that the MCO has no data to report for the identified report. The report must be identified by name and number in the submission e-mail.

However, if the MCO does not follow one of these two options, OMPP will assume that the MCO omitted the report or the reporting data.

Inserting Comments

Many of the Excel Database files include a "Comments" field to allow the MCO to insert additional text regarding the data in the file. When a "Comments" field is not included on the data file, the MCO's users can provide comments in the submission e-mail or on the Attestation Sheet that must accompany all data submissions.

[The remainder of this page has been intentionally left blank.]

MCO Name: _____

MCO Executive Name:_____

MCO Executive Signature:_____ Date: _____

In accordance with 42 CFR 438, subpart H, the MCO must submit all data under the signature of either its Financial Officer or Executive leadership (e.g., President, Chief Executive Officer, Executive Director) certifying the accuracy, truthfulness and completeness of the MCO's data. The MCO should indicate which reports and for what reporting period(s) the MCO is submitting its data in the "Reporting Period" field, have its Executive sign the attestation document and submit the signed attestation document in protected document format (pdf) electronically or via facsimile (FAX) to OMPP and the monitoring contractor with any data submission.

Item No.	Report Number	Report Title	Reporting Period
Systems and Claims Reports			
1	QR-S1	Claims Processing Summary	
2	QR-S2	Adjudicated Claims Inventory Summary	
3	QR-S3	Top Ten Claims Denial Reasons	
Member Services Reports			
4	MO-M1	Member Helpline Performance	
5	MO-M2	Member Grievances	
6	MO-M3	Member Appeals	
7	QR-M1	FSSA Hearings and Appeals	
8	AN-M1	Summary of Consumer Assessment of Health Plans Survey (CAHPS®)	
Network Development and Access Reports			
9	QR-N1	Promotional, Educational, Outreach and Incentive Materials Inventory and Distribution	MCO On-site
10	AN-N1	Network Geographic Access Assessment	
11	AN-N2	Provider Directory	
12	AN-N3	Subcontractor Compliance Summary Report	
13	AN-N4	24 Hour Availability Audit	
Provider Services Reports			
14	MO-P1	Provider Helpline Performance	
15	QR-P1	Informal Provider Claims Disputes	
16	QR-P2	Formal Provider Claims Disputes	
17	QR-P3	Binding Arbitration	

Item No.	Report Number	Report Title	Reporting Period
Quality Management and Improvement Reports			
18	QR-Q1	Quality Management and Improvement Committee Meeting Minutes	MCO On-site
19	QR-Q2	Medical Necessity Review Log	MCO On-site
20	AN-Q1	Quality Management and Improvement Work Plan	
21	AN-Q3	HEDIS® Work Plan	
22	AN-Q2	HEDIS® Data Submission Tool (DST)	
23	AN-Q3	HEDIS® Baseline Assessment Tool (BAT)	
24	AN-Q4	HEDIS® Compliance Auditor's Final Report	
25	AN-Q5	Asthma Common Measures	
Utilization Reports			
26	SA-CRCS-1	Capitation Rate Calculation Sheet	
27	SA-CRCS-2	Maternity Capitation Rate Calculation Sheet	
Financial Reports			
28	QR-F1	Indicators of Financial Stability	
29	QR-IDOI	Indiana Department of Insurance (IDOI) Filing	
30	SA-F1	Stop Loss	
31	AN-PIP	Physician Incentive Plan	CMS On-site
32	AN-F1	Insurance Premium Notice	
33	AN-FQHC	Reimbursement for FQHC and RHC Services	
Annual Single Source Prior Authoirzation Drug Listing (DUR) Reports			
34	AN-DUR-1	PDL Comparison of Select Therapeutic Classes, Open Access with No Restrictions	
35	AN-DUR-2	PDL Comparison of Select Therapeutic Classes, Clinical Edits with Rationale	
36	AN-DUR-3	Number of Prior Authorizations by Drug	
37	AN-DUR-4	Pharmacy Prior Authorizations	
38	AN-DUR-5	Pharmacy-related Grievances	
Other Data Reports			

General Report Description	
QR-S1 Claims Processing Summary	
Purpose	Assess the MCO's claims processing productivity and timeliness in adjudicating provider claims.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report by month. The MCO must submit the report to OMPP and the monitoring contractor by the last day of the month following the end of the reporting quarter. Unless specifically indicated otherwise, the following definitions apply in all OMPP performance claims reports: **Claim:** A claim is a billing encounter notice submitted for reimbursement consideration or (health care) utilization documentation that itemizes (health care) service(s) (i.e., claim line items) that have been rendered to a member. **UB-92 Claim:** Claim form for institutional services; under the Health Insurance Portability and Accountability Act (HIPAA), electronically submitted institutional claims are referred to as 837I claims. Unless specifically indicated otherwise, the term UB-92 is used for either paper or electronically submitted institutional claims. **CMS 1500 Claim:** Claim form for professional services mandated; under the Health Insurance Portability and Accountability Act (HIPAA), electronically submitted claims are referred to as 837P claims. Unless specifically indicated otherwise, the term CMS 1500 is used for either paper or electronically submitted professional claims. **Adjudicated Claim:** A claim that has been received by the MCO and processed through its claims system as either clean or unclean, paid or denied. **Replacement Claim:** A claim that the MCO has previously adjudicated but has been resubmitted for reprocessing (i.e., adjustment). (Continued on the next page.)

Comments/ Recommendations (Continued)	(Continued from the previous page.) **Clean Claim:** A claim in which all information required for processing the claim is on the claim form (see IC 12-15-13-0.5 through IC 12-15-13-0.7). **Clean Claim Paid On Time:** For electronically submitted claims, a clean claim is paid on time when it is paid within 21 calendar days of the MCO's receipt. For paper submitted claims, a clean claim is paid on time when it is paid within 30 calendar days of the MCO's receipt. **Clean Claim Paid Late:** For electronically submitted claims, a clean claim is paid late when it is paid more than 21 calendar days of the MCO's receipt. For paper submitted claims, a clean claim is paid late when it is paid more than 30 calendar days after the MCO's receipt. **Denied Claim**: A denied claim is a billing encounter notice submitted for reimbursement consideration or (health care) utilization documentation that itemizes (health care) service(s) (i.e., claim line items) rendered to a person in which **all** the (health care) service(s) (i.e., claim line item(s)) are deemed NOT eligible/appropriate for full or partial reimbursement or (health care) utilization documentation. **Julian Date:** Represents the calendar day's number in the total days available in a calendar year (i.e., 365 days). A Julian date calculator, which converts standard calendar dates to Julian dates, can be accessed at the following website: http://www.nr.com/julian.html **Paid Claim**: A paid claim is a billing encounter notice submitted for reimbursement consideration or (health care) utilization documentation that itemizes (health care) service(s) (i.e., claim line items) rendered to a covered person eligible to receive the (health care) service(s) on the date rendered in which **at least one** of the (health care) services (i.e., claim line item(s)) is partially or fully reimbursable or deemed eligible for full or partial reimbursement if the submitting entity had not been pre-paid for the (health care) service(s). (Continued on the next page.)

Comments/ Recommendations (Continued)	(Continued from the previous page.) **Received Claim**: A claim that the MCO has accepted into its inventory management system for future adjudication. For the purposes of this report, rejected claims and replacement claims are not considered received claims. Rejected Claim: A claim that the MCO cannot accept into its inventory for future adjudication. Remittance Advice (RA) Date: The date the MCO generates the provider remittance advice for an adjudicated claim. Unclean Claim: A claim that is determined not to be a "clean claim".
Performance Measures	Per IC 12-15-13-1.7, the MCO must pay or deny clean electronically submitted claims within 21 calendar days of receipt and clean claims submitted on paper within 30 calendar days of receipt.
QR-S1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting quarter for which the MCO is submitting claims processing data.
Formula	Select the reporting period from the menu.
2. Claims Received – Electronic	
Qualifications/ Definitions	Indicate the number of electronically submitted claims, by month and by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims] received into the MCO's claims inventory management system during the reporting month. The MCO should not count rejected claims and replacement claims as received claims, if the MCO can identify these coming into inventory.
Formula	Number of claims received electronically.

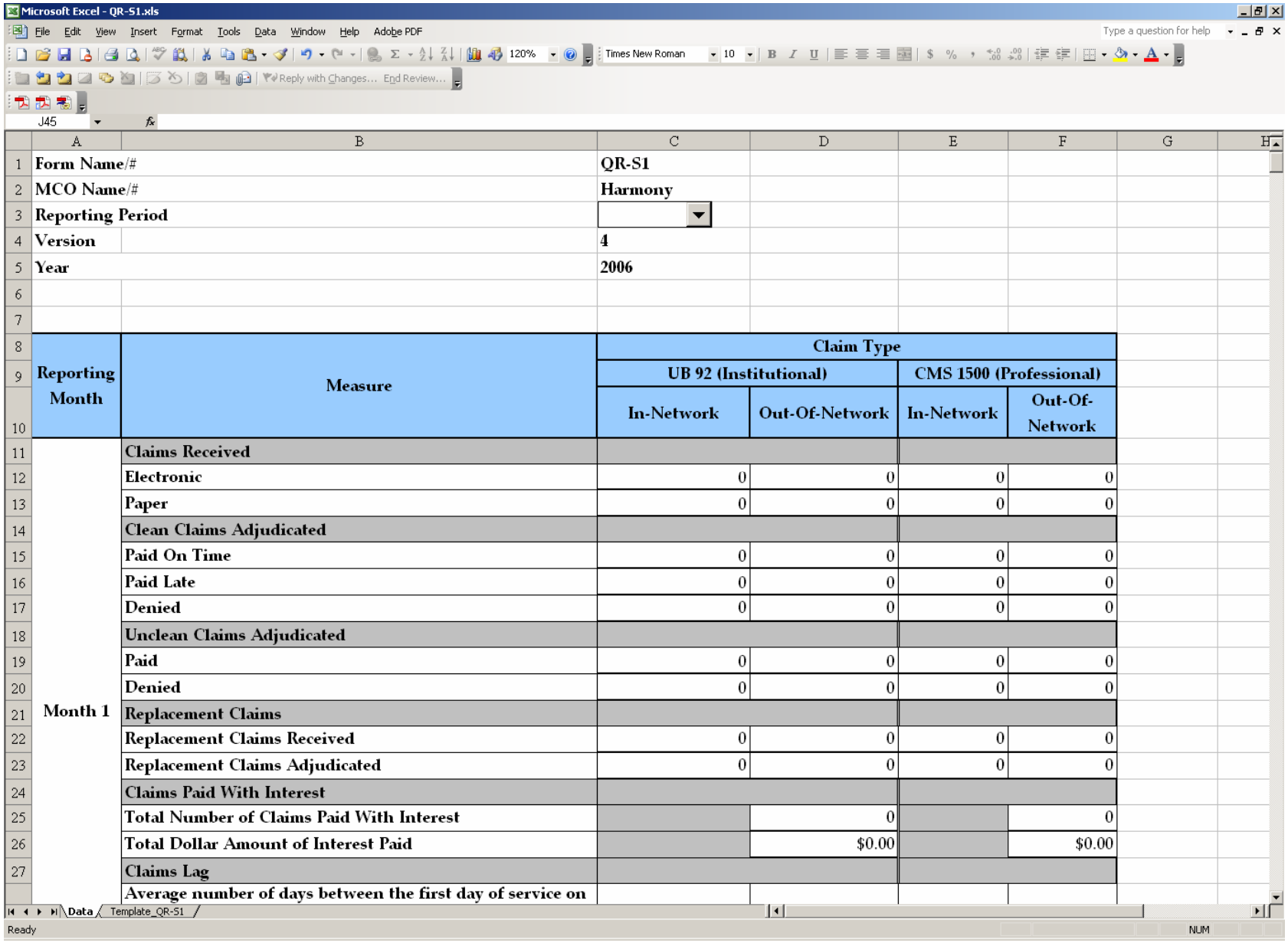
3. Claims Received – Paper	
Qualifications/ Definitions	Indicate the number of paper submitted claims, by month and by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims] received into the MCO's claims inventory management system during the reporting month. The MCO should not count rejected claims and replacement claims as received claims, if the MCO can identify these coming into inventory.
Formula	Number of claims received on paper.
4. Clean Claims Adjudicated Paid On Time	
Qualifications/ Definitions	For each month in the reporting quarter, indicate the number of clean claims adjudicated that the MCO paid on time during the month, by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional)]. Clean claims adjudicated during the month can include claims that were received during the month as well as those claims received in prior months. Clean claims adjudicated should not include replacement claims.
Formula	Number of clean claims paid on time.
5. Clean Claims Adjudicated Paid Late	
Qualifications/ Definitions	For each month in the reporting quarter, indicate the number of clean claims adjudicated that the MCO paid late during the month, by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims]. Clean claims adjudicated during the month can include claims that were received during the month as well as those claims received in prior months. Clean claims adjudicated should not include replacement claims.
Formula	Number of clean claims paid late.

6. Clean Claims Adjudicated Denied	
Qualifications/ Definitions	For each month in the reporting quarter, indicate the number of clean claims adjudicated that the MCO denied payment during the month, by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims]. Clean claims adjudicated during the month can include claims adjudicated that were received during the month as well as those claims received in prior months. Clean claims adjudicated should not include replacement claims.
Formula	Number of clean claims denied.
7. Unclean Claims Adjudicated Paid	
Qualifications/ Definitions	For each month in the reporting quarter, indicate the number of unclean claims adjudicated that the MCO paid during the month, by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims]. Unclean claims adjudicated during the month can include claims that were received during the month as well as those claims received in prior months. Unclean claims adjudicated should not include replacement claims.
Formula	Number of unclean claims paid.
8. Unclean Claims Adjudicated Denied	
Qualifications/ Definitions	For each month in the reporting quarter, indicate the number of unclean claims adjudicated that the MCO denied payment during the month, by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims]. Unclean claims adjudicated during the month can include claims that were received during the month as well as those claims received in prior months. Unclean claims adjudicated should not include replacement claims.
Formula	Number of unclean claims denied.

9. Replacement Claims Received	
Qualifications/ Definitions	For each month in the reporting quarter, indicate the total number of previously adjudicated claims received for reprocessing (i.e., replacement), by claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims].
Formula	Number of replacement claims received for reprocessing.
10. Replacement Claims Adjudicated	
Qualifications/ Definitions	Indicate by month, the total number of previously adjudicated claims that were reprocessed (i.e., replacement) during the month for each claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims]. Replacement Claims Adjudicated during the month can include claims that were received during the month as well as those claims received in prior months.
Formula	Number of replacement claims adjudicated.
11. Total Number of Claims Paid with Interest	
Qualifications/ Definitions	Indicate by month, the total number of claims that the MCO paid with interest for out-of-network providers by claim type [UB-92 (institutional) and CMS 1500 (professional) claims]. Per IC 12-15-13 the MCO must pay interest on all clean claims paid late to providers for which the MCO is responsible. The MCO should include replacement claims in this data.
Formula	Number of clean claims paid with interest.

12. Total Dollar Amount of Interest Paid	
Qualifications/ Definitions	Indicate by month, the total dollars in interest that the MCO paid to out-of-network providers by claim type [UB-92 (institutional) and CMS 1500 (professional) claims]. Per IC 12-15-13 the MCO must pay interest on all clean claims paid late to providers for which the MCO is responsible. The MCO should include replacement claims in this data.
Formula	Enter whole dollar amounts in $000,000,000.00 format.
13. Claims Lag – Average Number of Days Between the First Day of Service and the MCO's Receipt of Claims from Providers	
Qualifications/ Definitions	Indicate by month and claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims], the average number of calendar days between the first date of service listed on the claim and the date of the MCO received the provider's claim into the MCO's claims inventory management system.
Formula	Calculate the total number of calendar days between the first date of service listed on the claim and the date the MCO received the provider's claim into the MCO's claims inventory management by subtracting the Julian Date of the first date of service on the claim from the Julian date the MCO's receipt of the claim. Calculate the average number of days for each claim type by summing the total number of days between the date of service and receipt of claims and dividing by the total number of claims received.

14. Claims Lag – Average Number of Days from Receipt of Claims from Providers to Adjudication and Remittance to Providers	
Qualifications/ Definitions	Indicate by month and claim type [in-network and out-of-network, UB-92 (institutional) and CMS 1500 (professional) claims], the average number of calendar days between the date the MCO received the claim in its claims inventory management system and date the MCO generated a remittance advice to the provider [i.e., claims remittance advice (RA) date].
Formula	Calculate the total number of calendar days between the date the MCO received the providers claim into inventory and the date the MCO generated a remittance advice to the provider by subtracting the Julian Date of the date of receipt of the claim from the Julian date of the date the remittance advice was generated. Calculate the average number of days between the MCO's receipt of the provider claim and the MCO's generating its provider remittance advice for the claim by summing the number of calendar days all claims adjudicated for remittance and dividing by the total number of claims adjudicated for remittance.


Microsoft Excel - QR-S1.xls

	A	B	C	D	E	F	G	H
1	Form Name/#		QR-S1					
2	MCO Name/#		Harmony					
3	Reporting Period							
4	Version		4					
5	Year		2006					
6								
7								
8	Reporting Month	Measure	Claim Type					
9			UB 92 (Institutional)		CMS 1500 (Professional)			
10			In-Network	Out-Of-Network	In-Network	Out-Of-Network		
11	Month 1	Claims Received						
12		Electronic	0	0	0	0		
13		Paper	0	0	0	0		
14		Clean Claims Adjudicated						
15		Paid On Time	0	0	0	0		
16		Paid Late	0	0	0	0		
17		Denied	0	0	0	0		
18		Unclean Claims Adjudicated						
19		Paid	0	0	0	0		
20		Denied	0	0	0	0		
21		Replacement Claims						
22		Replacement Claims Received	0	0	0	0		
23		Replacement Claims Adjudicated	0	0	0	0		
24		Claims Paid With Interest						
25		Total Number of Claims Paid With Interest		0		0		
26		Total Dollar Amount of Interest Paid		$0.00		$0.00		
27		Claims Lag						
		Average number of days between the first day of service on						

MCO Name: _____

MCO name will be on the template.

Reporting Period_____

Select the reporting quarter from the menu.

Insert the appropriate response to each measure, by claim type, for each reporting month.

Reporting Month	Measure	Claim Type			
		UB 92 (Institutional)		CMS 1500 (Professional)	
		In-Network	Out-Of-Network	In-Network	Out-Of-Network
Month 1	**Claims Received**				
	Electronic				
	Paper				
	Clean Claims Adjudicated				
	Paid On Time				
	Paid Late				
	Denied				
	Unclean Claims Adjudicated				
	Paid				
	Denied				
	Replacement Claims				
	Replacement Claims Received				
	Replacement Claims Adjudicated				
	Claims Paid With Interest				
	Total Number of Claims Paid With Interest				
	Total Dollar Amount of Interest Paid				
	Claims Lag				
	Average number of days between the first day of service on claim and MCO's receipt of claim from provider.				
	Average number of days from receipt of claim by MCO to adjudication and remittance to provider.				

Enter whole dollar amounts in $000,000,000.00 format.

MCO Name: _____

Reporting Period_____

MCO name will be on the template.

Select the reporting quarter from the menu.

Insert the appropriate response to each measure, by claim type, for each reporting month.

Reporting Month	Measure	Claim Type			
		UB 92 (Institutional)		CMS 1500 (Professional)	
		In-Network	Out-Of-Network	In-Network	Out-Of-Network
Month 2	**Claims Received**				
	Electronic				
	Paper				
	Clean Claims Adjudicated				
	Paid On Time				
	Paid Late				
	Denied				
	Unclean Claims Adjudicated				
	Paid				
	Denied				
	Replacement Claims				
	Replacement Claims Received				
	Replacement Claims Adjudicated				
	Claims Paid With Interest				
	Total Number of Claims Paid With Interest				
	Total Dollar Amount of Interest Paid				
	Claims Lag				
	Average number of days between the first day of service on claim and MCO's receipt of claim from provider.				
	Average number of days from receipt of claim by MCO to adjudication and remittance to provider.				

Enter whole dollar amounts in $000,000,000.00 format.

MCO Name: _____

Reporting Period_____

MCO name will be on the template.

Select the reporting quarter from the menu.

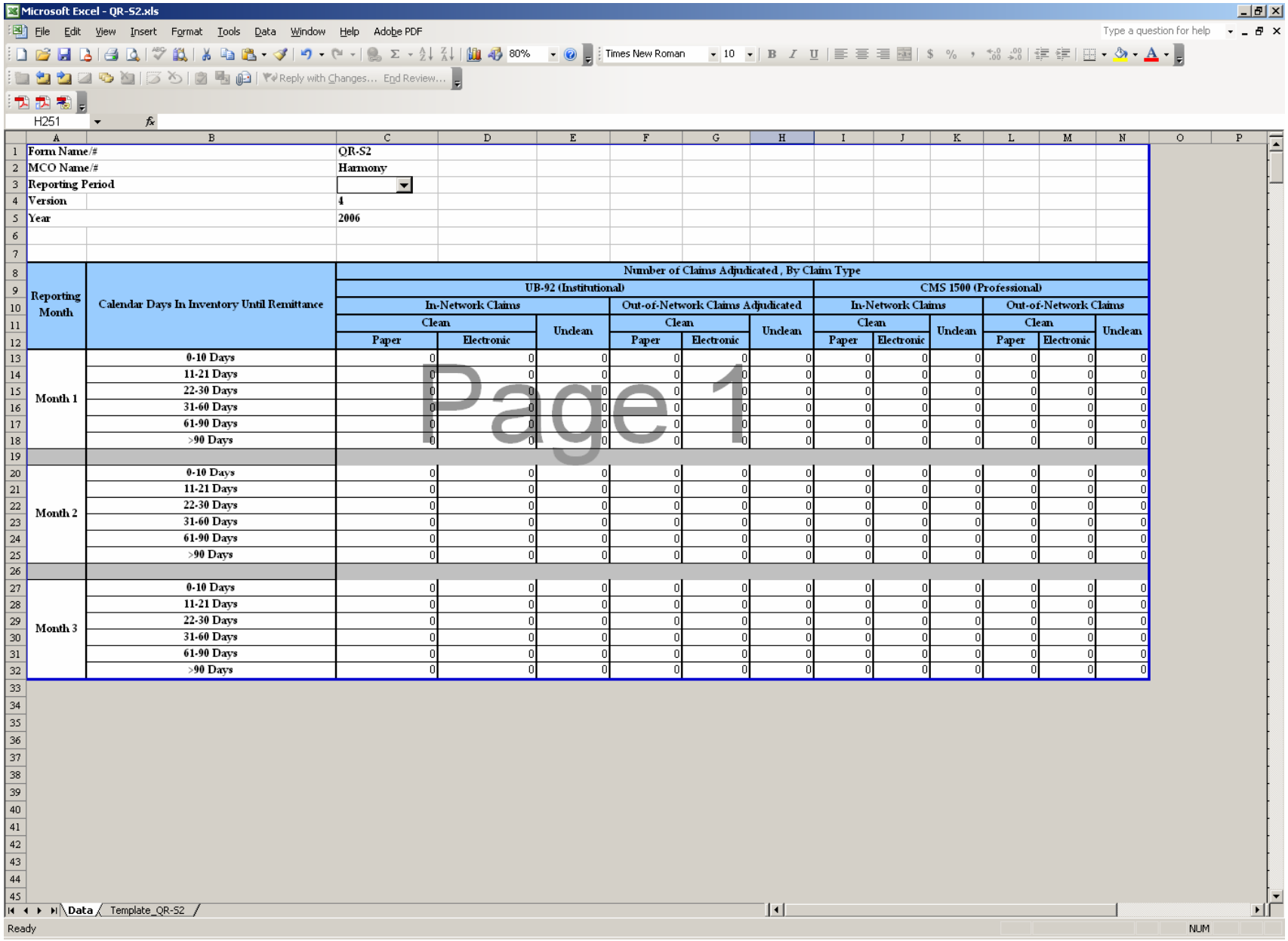
Insert the appropriate response to each measure, by claim type, for each reporting month.

Reporting Month	Measure	Claim Type			
		UB 92 (Institutional)		CMS 1500 (Professional)	
		In-Network	Out-Of-Network	In-Network	Out-Of-Network
Month 3	**Claims Received**				
	Electronic				
	Paper				
	Clean Claims Adjudicated				
	Paid On Time				
	Paid Late				
	Denied				
	Unclean Claims Adjudicated				
	Paid				
	Denied				
	Replacement Claims				
	Replacement Claims Received				
	Replacement Claims Adjudicated				
	Claims Paid With Interest				
	Total Number of Claims Paid With Interest				
	Total Dollar Amount of Interest Paid				
	Claims Lag				
	Average number of days between the first day of service on claim and MCO's receipt of claim from provider.				
	Average number of days from receipt of claim by MCO to adjudication and remittance to provider.				

Enter whole dollar amounts in $000,000,000.00 format.

General Report Description	
QR-S2 – Adjudicated Claims Inventory Summary	
Purpose	Assess the MCO's efficiency in claims processing and remitting adjudicated claims within the State required timeframes.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report by month. The MCO must submit the report to OMPP and the monitoring contractor by the last day of the month following the end of the reporting quarter. OMPP defines specific claims terms in the Claims Processing Summary (QR-S1) report for all claims related reports.
Performance Measures	Per IC 12-15-13-1.7, the MCO must pay or deny clean electronically submitted claims within 21 calendar days of receipt and clean paper submitted claims within 30 calendar days of receipt.
QR-S2 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the calendar quarter for which adjudicated claims inventory data is being reported.
Formula	Select the reporting quarter from the menu.
2. In-Network Claims Adjudicated	
Qualifications/ Definitions	Indicate the number of claims from in-network providers that were adjudicated, sorted by claim type [i.e., UB-92 (institutional) and CMS 1500 (professional)] in each month of the reporting quarter. The MCO may omit replacement claims from this data. The information required for in-network claims adjudicated includes: • Number of calendar days between the date the claim was received into the MCO's inventory and the date the MCO sent a remittance advice to the provider after adjudicating the claim • The MCO's determination of the claim being clean or unclean • Clean claim submission type (i.e., paper or electronic)

2. In-Network Claims Adjudicated (Continued)	
Formula	Calculate as the number of calendar days from date of receipt into inventory to date of the remittance advice by subtracting the Julian Date of receipt of the claim into inventory from the Julian Date of the remittance advice.
3. Out-of-Network Claims Adjudicated	
Qualifications/ Definitions	Indicate the number of claims from out-of-network providers that were adjudicated, sorted by claim type [i.e., UB-92 (institutional) and CMS 1500 (professional)] in each month of the reporting quarter. The MCO may omit replacement claims from this data. The information required for out-of-network claims adjudicated includes: • Number of calendar days between the date the claim was received into the MCO's inventory and the date the MCO sent a remittance advice to the provider after adjudicating the claim • The MCO's determination of the claim being clean or unclean • Clean claim submission type (i.e., paper or electronic)
Formula	Calculate as the number of calendar days from date of receipt into inventory to date of the remittance advice by subtracting the Julian date of receipt of the claim into inventory from the Julian date of the remittance advice.



Microsoft Excel - QR-S2.xls

Form Name/#	QR-S2	
MCO Name/#	Harmony	
Reporting Period		
Version	4	
Year	2006	

Reporting Month	Calendar Days In Inventory Until Remittance	Number of Claims Adjudicated, By Claim Type											
		UB-92 (Institutional)						CMS 1500 (Professional)					
		In-Network Claims			Out-of-Network Claims Adjudicated			In-Network Claims			Out-of-Network Claims		
		Clean		Unclean	Clean		Unclean	Clean		Unclean	Clean		Unclean
		Paper	Electronic		Paper	Electronic		Paper	Electronic		Paper	Electronic	
Month 1	0-10 Days	0	0	0	0	0	0	0	0	0	0	0	0
	11-21 Days	0	0	0	0	0	0	0	0	0	0	0	0
	22-30 Days	0	0	0	0	0	0	0	0	0	0	0	0
	31-60 Days	0	0	0	0	0	0	0	0	0	0	0	0
	61-90 Days	0	0	0	0	0	0	0	0	0	0	0	0
	>90 Days	0	0	0	0	0	0	0	0	0	0	0	0
Month 2	0-10 Days	0	0	0	0	0	0	0	0	0	0	0	0
	11-21 Days	0	0	0	0	0	0	0	0	0	0	0	0
	22-30 Days	0	0	0	0	0	0	0	0	0	0	0	0
	31-60 Days	0	0	0	0	0	0	0	0	0	0	0	0
	61-90 Days	0	0	0	0	0	0	0	0	0	0	0	0
	>90 Days	0	0	0	0	0	0	0	0	0	0	0	0
Month 3	0-10 Days	0	0	0	0	0	0	0	0	0	0	0	0
	11-21 Days	0	0	0	0	0	0	0	0	0	0	0	0
	22-30 Days	0	0	0	0	0	0	0	0	0	0	0	0
	31-60 Days	0	0	0	0	0	0	0	0	0	0	0	0
	61-90 Days	0	0	0	0	0	0	0	0	0	0	0	0
	>90 Days	0	0	0	0	0	0	0	0	0	0	0	0

MCO name will be on the template.

MCO Name: _____

Reporting Period_____

Select the reporting quarter from the menu.

Reporting Month	Calendar Days In Inventory Until Remittance	Number of Claims Adjudicated, By Claim Type											
		UB-92 (Institutional)						CMS 1500 (Professional)					
		In-Network Claims Adjudicated			Out-of-Network Claims Adjudicated			In-Network Claims Adjudicated			Out-of-Network Claims Adjudicated		
		Clean		Unclean	Clean		Unclean	Clean		Unclean	Clean		Unclean
		Paper	Electronic		Paper	Electronic		Paper	Electronic		Paper	Electronic	
Month 1	0-10 Days												
	11-21 Days												
	22-30 Days												
	31-60 Days												
	61-90 Days												
	>90 Days												
Month 2	0-10 Days												
	11-21 Days												
	22-30 Days												
	31-60 Days												
	61-90 Days												
	>90 Days												
Month 3	0-10 Days												
	11-21 Days												
	22-30 Days												
	31-60 Days												
	61-90 Days												
	>90 Days												

Indicate the number of in-network 837I claims adjudicated during the reporting period, by the number of days in inventory, clean or unclean status and submission type.

Indicate the number of in-network 837P claims adjudicated during the reporting period, by the number of days in inventory, clean or unclean status and submission type.

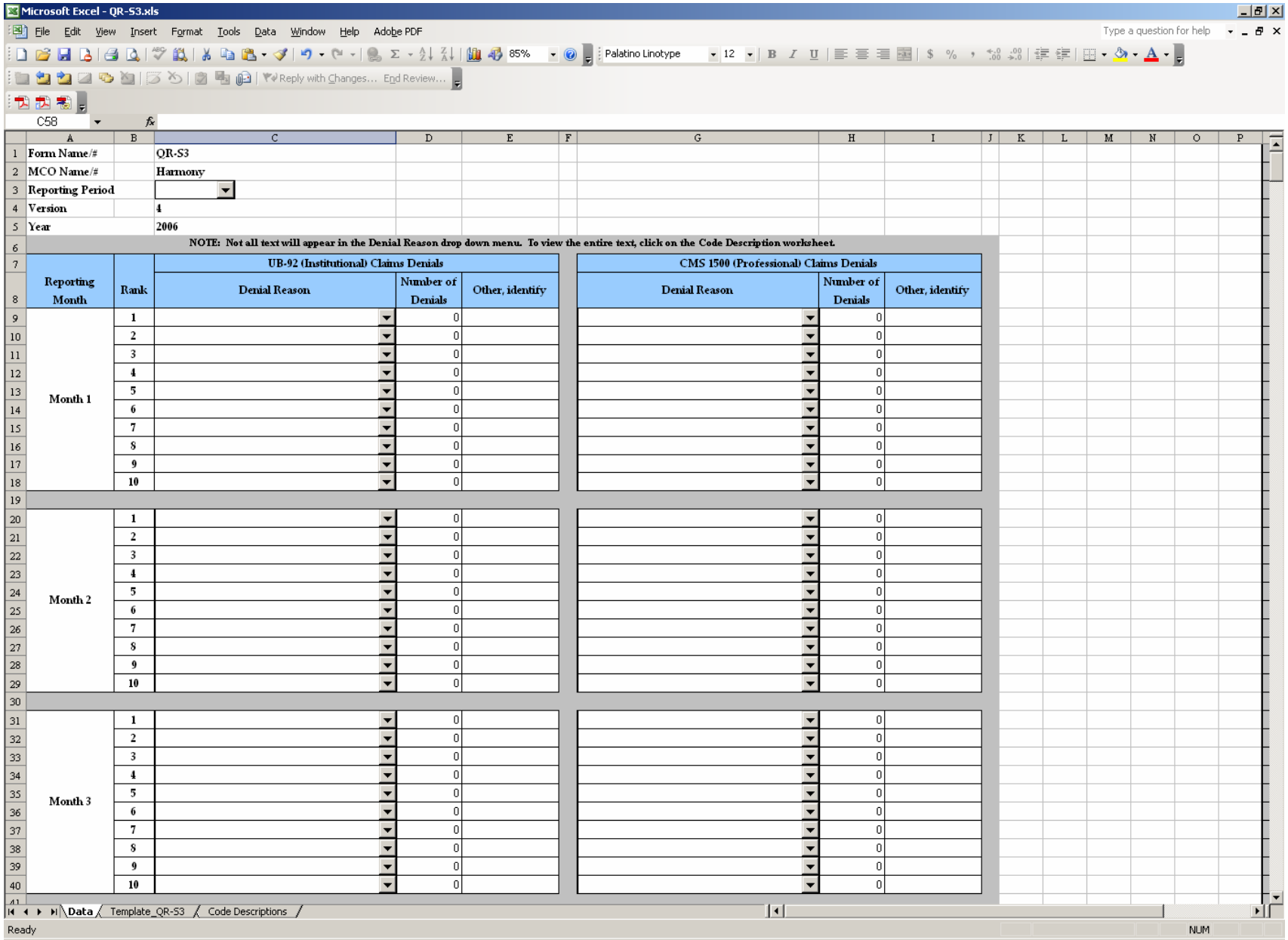
Indicate the number of out-of-network 837I claims adjudicated during the reporting period, by the number of days in inventory, clean or unclean status and submission type.

Indicate the number of out-of-network 837P claims adjudicated during the reporting period, by the number of days in inventory, clean or unclean status and submission type.

General Report Description	
QR-S3 Top Ten Claims Denial Reasons	
Purpose	Assess the MCO adjudicated claims denial reasons and determine if common reasons for claims denials could indicate opportunities for improving claims submissions through additional provider education and outreach.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report by month. The MCO must submit the report to the monitoring contractor and OMPP by the last day of the month following the end of the reporting quarter. OMPP defines specific claims terms in the Claims Processing Summary (QR-S1) report for all claims related reports.
Performance Measures	OMPP has not indicated specific performance measures at this time.
QR-S3 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting quarter for which the MCO is submitting claims denial data.
Formula	Select the reporting period from the menu.
2. Rank	
Qualifications/ Definitions	Rank the most frequent denial reasons for the claims adjudicated and denied during each month of the reporting period from one to ten sorted by claim type [i.e., UB-92 (institutional) and CMS 1500 (professional)].
Formula	Rank the reasons consecutively 1 through 10 with the most frequent reason first.
3. Denial Reason	
Qualifications/ Definitions	Select denial reasons from the menu. Denial reasons have been identified using standardized Health Insurance Portability and Accountability Act (HIPAA) claims adjudication reason and remittance advice remarks. (Continued on the next page.)

Qualifications/ Definitions	(Continued from the previous page.) These descriptions can be accessed via the internet at: http://www.wpc-edi.com/codes/Codes.asp A8 Claim denied; ungroupable DRG 16 Claim/service lacks information which is needed for adjudication N130 Consult plan benefit documents for information about restrictions for this service 28 Coverage not in effect at the time the service was provided 18 Duplicate claim/service 96 Non-covered charges N30 Patient ineligible for this service N52 Patient not enrolled in the billing provider's managed care plan on the date of service N45 Payment based on authorized amount 62 Payment denied/reduced for absence of, or exceeded, pre-certification/authorization MA119 Provider level adjustment for late claim filing applies to this claim MA04 Secondary payment cannot be considered without the identity of or payment M86 Service denied because payment already made for similar procedure within set time frame N22 This procedure code was changed because it more accurately describes the services rendered MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are affordable because the claim is not processable. Please submit a new claim with the complete/ correct information 000 Other, identify
Formula	Enter appropriate HIPAA denial reasons; if "Other, identify" include the HIPAA reason code number and text reason description limited to 50 alpha/ numeric characters.

4. Number of Denials	
Qualifications/ Definitions	Indicate the total number of adjudicated claims denied during each reporting month for each reason listed by claims type [i.e., UB-92 (institutional) and CMS 1500 (professional)].
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.



Microsoft Excel - QR-S3.xls

Form Name/#	QR-S3	
MCO Name/#	Harmony	
Reporting Period		
Version	4	
Year	2006	

NOTE: Not all text will appear in the Denial Reason drop down menu. To view the entire text, click on the Code Description worksheet.

Reporting Month	Rank	UB-92 (Institutional) Claims Denials			CMS 1500 (Professional) Claims Denials		
		Denial Reason	Number of Denials	Other, identify	Denial Reason	Number of Denials	Other, identify
Month 1	1		0			0	
	2		0			0	
	3		0			0	
	4		0			0	
	5		0			0	
	6		0			0	
	7		0			0	
	8		0			0	
	9		0			0	
	10		0			0	
Month 2	1		0			0	
	2		0			0	
	3		0			0	
	4		0			0	
	5		0			0	
	6		0			0	
	7		0			0	
	8		0			0	
	9		0			0	
	10		0			0	
Month 3	1		0			0	
	2		0			0	
	3		0			0	
	4		0			0	
	5		0			0	
	6		0			0	
	7		0			0	
	8		0			0	
	9		0			0	
	10		0			0	

Data / Template_QR-S3 / Code Descriptions

Ready

MCO Name: _____ MCO name will be on the template.

Reporting Period_____ Select reporting quarter from the menu.

Reporting Month	Rank	UB-92 (Institutional) Claims Denials		CMS 1500 (Professional) Claims Denials	
		Denial Reason	Number of Denials	Denial Reason	Number of Denials
Month 1	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
	9				
	10				
Month 2	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
	9				
	10				
Month 3	1				
	2				
	3				
	4				
	5				
	6				
	7				
	8				
	9				
	10				

Identify the denial reason using standardized HIPAA claims adjudication reasons and remittance advice remarks from options menu.

Identify the total number of adjudicated claims denied during the reporting month for each reason.

Frequent Denial Reasons

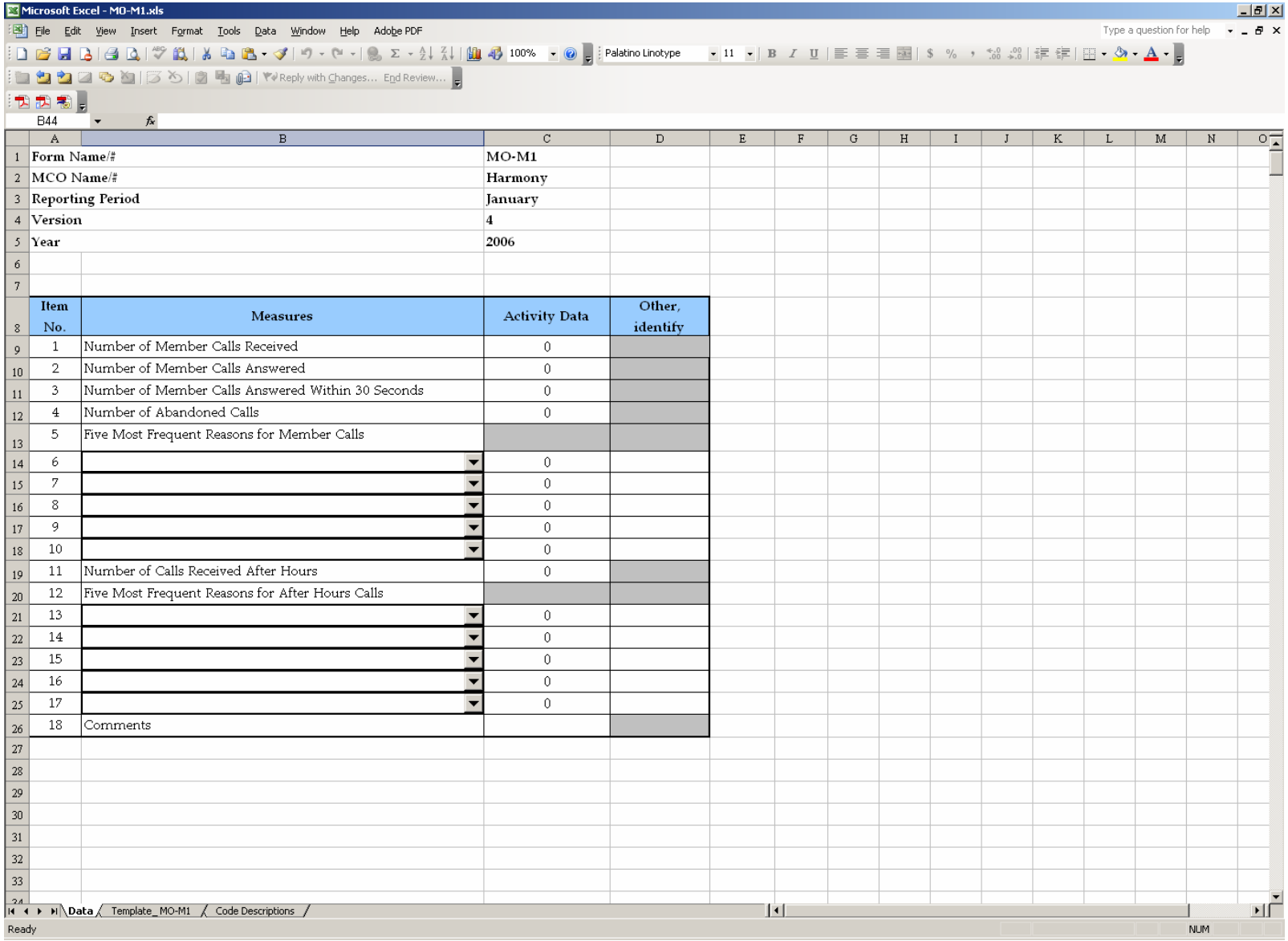
A8	Claim denied; ungroupable DRG
16	Claim/service lacks information which is needed for adjudication
N130	Consult plan benefit documents for information about restrictions for this service
28	Coverage not in effect at the time the service was provided
18	Duplicate claim/service
96	Non-covered charges
N30	Patient ineligible for this service
N52	Patient not enrolled in the billing provider's managed care plan on the date of service
N45	Payment based on authorized amount
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
MA119	Provider level adjustment for late claim filing applies to this claim
MA04	Secondary payment cannot be considered without the identity of or payment
M86	Service denied because payment already made for similar procedure within set time frame
N22	This procedure code was changed because it more accurately describes the services rendered
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are affordable because the claim is not processable. Please submit a new claim with the complete/correct information
0	Other, identify

General Report Description	
MO-M1 Member Helpline Performance	
Purpose	Monitor MCO's availability to provide service to its members calling the MCO's Member Helpline.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a monthly report. The MCO must submit the report to the monitoring contractor and OMPP by the 15th day of the month following the end of the reporting period. At OMPP's discretion, the MCO may submit monthly data on a quarterly basis by the last day of the month following the end of the reporting quarter. OMPP is providing one template for each month of the year. The MCO must submit its data using the appropriately named template. For example, MO-M1_Apr_06.xls is the template name for April's data.
Performance Measures	The MCO must maintain its average monthly telephone service for its member services helpline with service efficiency at 85 percent of calls received being answered by a live voice within 30 seconds (i.e., a 85 percent service efficiency rate) and less than five percent of the calls received in the Member Helpline remaining unanswered.
MO-M1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Identify the calendar year, reporting month or quarter for which Member Helpline data is being submitted.
Formula	This field will auto-fill to identify the reporting period.
2. Number of Member Calls Received	
Qualifications/ Definitions	Identify the total number of member calls received by the MCO's Member Helpline during open hours of operation, including calls in which the member calls directly into the Member Helpline, transfers into the Member Helpline or selects a member services option placing the member into the call queue. This does not apply to other external call centers (e.g., pharmacy).
Formula	Total number of calls received in the Member Helpline automatic call distribution (ACD) call queue. OMPP will calculate year-to-date activity from monthly data.

3. Number of Member Calls Answered	
Qualifications/ Definitions	Identify the total number of member calls answered on the Member Helpline in the reporting month. This number should not be greater than the number of calls received and should include the number of calls answered within 30 seconds by a live voice.
Formula	Total number of calls received and answered that enter the Member Helpline ACD call queue. OMPP will calculate year-to-date activity from monthly data.
4. Number of Calls Answered Live Within 30 Seconds	
Qualifications/ Definitions	Identify the number of member calls answered within 30 seconds by live voice on the Member Helpline in the reporting month. This number should not be greater than the number of calls received.
Formula	Total number of calls received and answered by a live voice within 30 seconds of the call entering the Member Helpline ACD call queue. OMPP will calculate year-to-date activity from monthly data.
5. Number of Abandoned Calls	
Qualifications/ Definitions	Identify the number of calls received into the MCO's Member Helpline during open hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Formula	Enter number of calls abandoned. OMPP will calculate year-to-date activity from monthly data. OMPP will calculate MCO's abandonment rate using number of calls received during open hours of operation but not answered before disconnecting divided by total number of calls received, times 100.
6. Five Most Frequent Reasons for Member Calls	
Qualifications/ Definitions	Identify the five most frequent reasons for members calling the Member Helpline by the reasons below. The reasons for the calls should be tabulated from all calls answered, and listed from the reason with the highest to the lowest number of calls. <u>Most Frequent Reasons</u> Member Assistance/General Information Other, Identify Providers Billing Members for Services Request Assistance to Fill Prescriptions (Continued on the next page.)

6. Five Most Frequent Reasons for Member Calls (Continued)	
Qualifications/ Definitions (Continued)	(Continued from the previous page.) Request Benefit Information Request ID Card Request Pharmacy Information Request PMP Change Request PMP Information Request Transportation Information (exclude calls to schedule or arrange transportation) Verify Eligibility
Formula	Enter a reason from the menu consecutively with the most frequent reason first; if "Other, identify", enter a text reason limited to 50 alpha/numeric characters. OMPP will calculate year-to-date activity by reason by using monthly data.
7. Total Number of Calls for Top Five Reasons	
Qualifications/ Definitions	Identify the total number of member calls received for each of the top five reasons. The sum of the number of calls by reason should not be greater than the number of total calls answered.
Formula	Enter number of calls. OMPP will calculate year-to-date activity by reason codes using monthly data.
8. Number of After Hours Member Calls Received	
Qualifications/ Definitions	Indicate the number of member calls received after business hours on the MCO's after-hours voice messaging system for the Member Helpline.
Formula	Enter number of calls. OMPP will calculate year-to-date activity using monthly data.
9. Five Most Frequent Reasons for After Hours Member Calls	
Qualifications/ Definitions	Identify the five most frequent reasons for members calling the Member Helpline after hours by the reasons below, and list from the reason with the highest to the lowest number of calls <u>Frequent Reasons</u> Member Assistance/General Information Other, Identify Providers Billing Members for Services (Continued on the next page.)

9. Five Most Frequent Reasons for After Hours Member Calls (Continued)	
Qualifications/ Definitions (Continued)	(Continued from the previous page.) Request Assistance to Fill Prescriptions Request Benefit Information Request ID Card Request Pharmacy Information Request PMP Change Request PMP Information Request Transportation Information (exclude calls to schedule or arrange transportation) Verify Eligibility
Formula	Select a reason from the menu; if "Other, identify" enter a text reason in 50 alpha/numeric characters. OMPP will calculate year-to-date activity by reason code using monthly data.
10. Total Number of After Hours Calls for Top Five Reasons	
Qualifications/ Definitions	Identify the total number of after hours member calls received for each of the top five reasons. The sum of the number of calls by reason should not be greater than the number of after hours members calls received.
Formula	Enter number of calls by reason. OMPP will calculate year-to-date activity by reason codes using monthly data.
11. Comments	
Qualifications/ Definitions	Enter additional details regarding the performance and outcomes of the Member Helpline as the MCO deems necessary.
Formula	Limit to 100 alpha/numeric characters.



Microsoft Excel - MO-M1.xls

	A	B	C	D
1	Form Name/#		MO-M1	
2	MCO Name/#		Harmony	
3	Reporting Period		January	
4	Version		4	
5	Year		2006	
6				
7				
8	Item No.	Measures	Activity Data	Other, identify
9	1	Number of Member Calls Received	0	
10	2	Number of Member Calls Answered	0	
11	3	Number of Member Calls Answered Within 30 Seconds	0	
12	4	Number of Abandoned Calls	0	
13	5	Five Most Frequent Reasons for Member Calls		
14	6		0	
15	7		0	
16	8		0	
17	9		0	
18	10		0	
19	11	Number of Calls Received After Hours	0	
20	12	Five Most Frequent Reasons for After Hours Calls		
21	13		0	
22	14		0	
23	15		0	
24	16		0	
25	17		0	
26	18	Comments		

MCO name will be on the template.

MCO Name: _____

Reporting Period_____

Auto-fill for reporting period.

Indicate the total number of member calls answered that enter the Member Helpline ACD call queue.

Indicate the total number of member calls that the Helpline received during the reporting month.

Item No.	Measures	Activity Data
1	Number of Member Calls Received	
2	Number of Member Calls Answered	
3	Number of Member Calls Answered Live 30 Seconds	
4	Number of Abandoned Calls	
5	Five Most Frequent Reasons for Member Calls	
6	1	
7	2	
8	3	
9	4	
10	5	
11	Number of Calls Received After Hours	
12	Five Most Frequent Reasons for After Hours Calls	
13	1	
14	2	
15	3	
16	4	
17	5	
18	Comments	

Indicate the total number of member calls answered by a live voice within 30 seconds of entering the Member Helpline ACD call queue.

Insert the number of calls received in Member Helpline that were abandoned by the caller or system before being answered by a live voice.

Select a reason from the menu; if "Other, identify" limit reason text to 50 alpha/ numeric characters; enter the number of calls received for the reason indicated from the highest number to the lowest number.

Insert the number of member calls recorded on the MCO's messaging system for after hours calls during the reporting period.

Select a reason from the menu: if "Other, identify" limit reason text to 50 alpha/numeric characters; enter the number of calls received for the reason indicated from the highest number to the lowest number.

Optional comments limited to 100 alpha/numeric characters.

Frequent Reasons for Member Calls

Member Assistance/General Information

Other, identify

Providers Billing Members for Services

Request Assistance to Fill Prescriptions

Request Benefit Information

Request ID Card

Request Pharmacy Information

Request PMP Change

Request PMP Information

Request Transportation Information (exclude calls to schedule or arrange transportation)

Verify Eligibility

General Report Description	
MO-M2 Member Grievances	
Purpose	Monitor the volume and timely resolution of the MCO's member grievances monthly, identifying member grievance activity related to children with special needs and Package C members separately.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a monthly report. The MCO must submit the report to the monitoring contractor and OMPP by the 15th day of the month following the end of the reporting period. At OMPP's discretion, the MCO may submit monthly data on a quarterly basis by the last day of the month following the end of the reporting quarter. The MCO must identify data for children with special needs and Package C members separately in the report. Special needs children should also include "First Steps" members. The MCO must refer to Table MO-M2: Member Grievances Matrix (attached) for more information on the member grievances policy, definitions and timelines. OMPP is providing one template for each month of the year. The MCO must submit its data using the appropriately named template. For example, MO-M2_Apr_06.xls is the template name for April's data.
Performance Measures	The MCO should resolve all member grievances within 20 calendar days of receipt.
MO-M2 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting period for which member grievance data is being submitted.
Formula	This field will auto-fill.

2. Member Months	
Qualifications/ Definitions	Identify the number of member months (i.e., number of members enrolled) for the MCO during the reporting month.
Formula	Enter the number of member months.
3. Total Number of Grievances Received	
Qualifications/ Definitions	Enter the number of member grievances received (including those from children with special needs and Package C members) during the reporting month as of the last day of the reporting period. Also, indicate the number of member grievances received during the reporting month for children with special needs and Package C members each separately.
Formula	Enter total numbers. Note: Enter number into the "Month Total" field before entering data into the "Special Needs Month Total" or "Package C Month Total" fields. OMPP will calculate member appeals by 1,000 member months and calculate year-to-date activity from monthly data.
4. Total Number of Grievances Pending From Previous Reporting Periods	
Qualifications/ Definitions	Insert the total number of member grievances pending resolution (including those from children with special needs and Package C members) at the end of the previous reporting period. Also, identify the total number of member grievances pending a resolution regarding children with special needs and Package C members each separately.
Formula	Enter total numbers. OMPP will calculate year-to-date activity using monthly data.
5. Average Number of Days to Resolve Grievances	
Qualifications/ Definitions	Calculate resolution times in business days from the date the MCO received the member grievance to the day the MCO notified the member of a resolution determination.
Formula	Calculate and enter the average number of business days. OMPP will calculate year-to-date activity using monthly data.

6. Number of Grievances Resolved	
Qualifications/ Definitions	Identify the total number of member grievances (including those from children with special needs and Package C members) that were resolved during the reporting month as of the last day of the reporting period. Also, indicate the number of member grievances resolved during the reporting month for children with special needs and Package C members each separately.
Formula	Enter total numbers. OMPP will calculate year-to-date activity from monthly data.
7. Number of Grievances Pending Resolution	
Qualifications/ Definitions	Identify the total number of member grievances pending resolution (including those from children with special needs and Package C members) at the end the reporting period as of the last day of the reporting period. Also, indicate the number of member grievances pending resolution at the end of the reporting period for children with special needs and Package C members each separately. In subsequent reports, this number should be reported until a resolution is determined under Item Number 3: "Total Number of Grievances Pending From Previous Reporting Periods."
Formula	This number will auto-fill. OMPP will calculate year-to-date activity from monthly data.
MO-M2 Report Log Data Elements	
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a monthly report log that supplements the Member Grievances (MO-M2) Report. The MCO must submit the report to the monitoring contractor and OMPP by the 15th day of the month following the end of the reporting period. At OMPP's discretion, the MCO may submit monthly data on a quarterly basis by the last day of the month following the end of the reporting quarter. The MCO should submit a report log each reporting period using the previous reporting period's log but updated with the current reporting period's member grievance activity. The report log must include all member grievances from reporting period to reporting period until the MCO completes the grievance process.

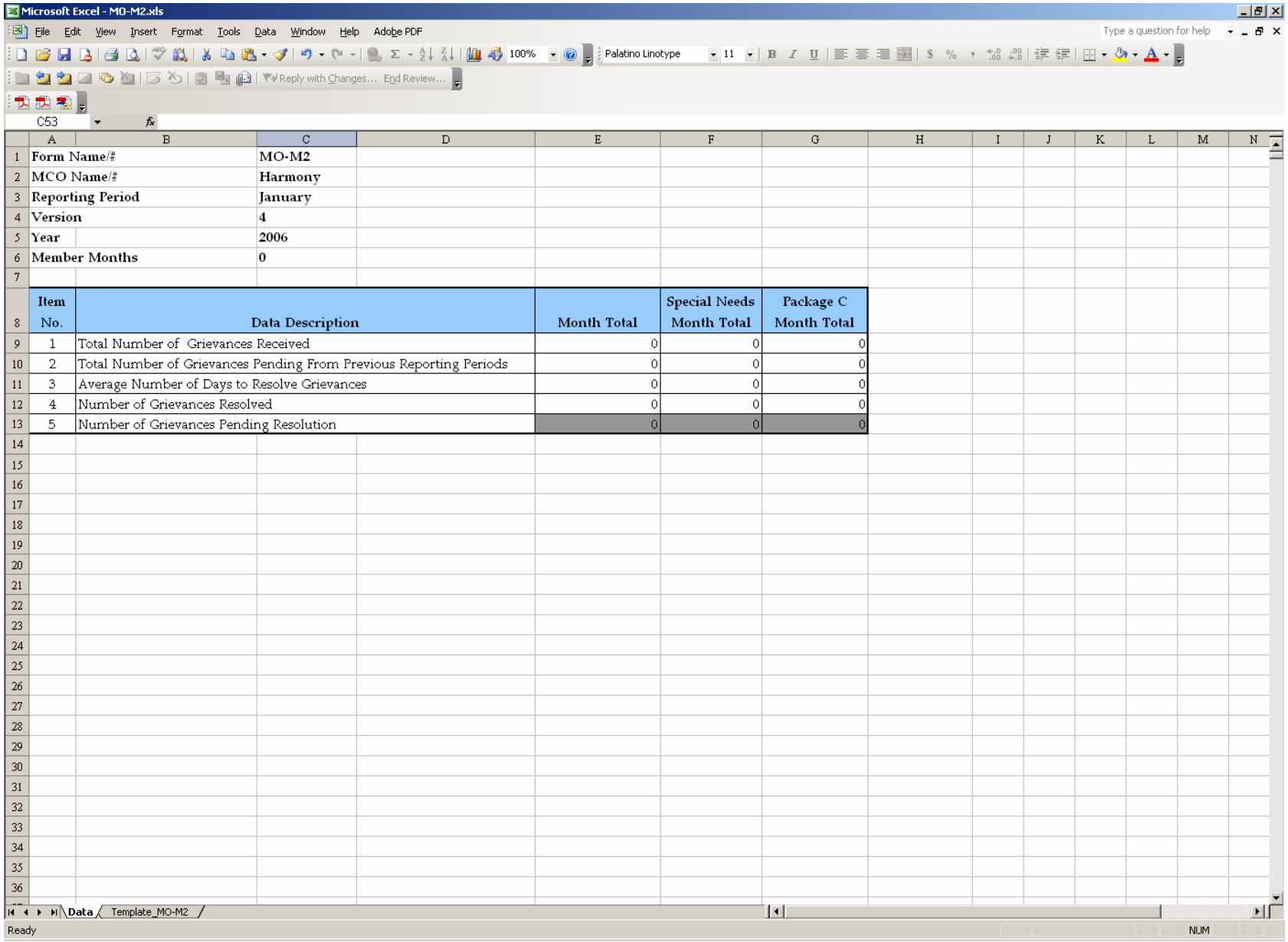
1. Reporting Period	
Qualifications/ Definitions	Enter the last month for which the MCO is reporting member grievance data.
Formula	Enter in MM/YYYY format.
2. Item No.	
Qualifications/ Definitions	Consecutively number all member grievances received, resolved or pending resolution during the reporting period.
Formula	This field will auto-fill to consecutively number all member grievances listed.
3. Member Indicator	
Qualifications/ Definitions	Indicate the type of member using the indicator descriptions below: <u>Member Indicator Descriptions</u> General member Package C member Special needs member
Formula	Select the member type from the menu.
4. Tracking Number	
Qualifications/ Definitions	Provide a unique tracking number for the member. The MCO may use the recipient identification number (RID) but must use the same unique tracking number for this member throughout the grievance and appeal process related to this specific issue. The tracking number can be the RID or any alpha/numeric code that the MCO assigns to the member for the purposes of reporting <u>all</u> member grievances and appeals related to one individual.
Formula	Limit the MCO-determined tracking number to 25 alpha/numeric characters.
5. Date Received	
Qualifications/ Definitions	Identify the date the MCO received the member grievance for all member grievances received, resolved or pending response during the reporting month.
Formula	Enter date in MM/DD/YYYY format. Note: This date must be January 1, 2005, or later.

6. Reason for Grievance	
Qualifications/ Definitions	Identify a brief reason for each member grievance received during the reporting month.
Formula	Limit 100 alpha/numeric characters.
7. Resolution Description	
Qualifications/ Definitions	If a resolution was made during the reporting period, enter a brief description of the resolution determination in narrative text. A resolution is considered complete when the MCO notifies the member of the resolution decision. If the resolution decision was not communicated to the member by the last day of the reporting period, leave this field blank and include this member grievance in subsequent reports until a resolution is complete.
Formula	Limit to 200 alpha/numeric characters.
8. Date Resolved	
Qualifications/ Definitions	Identify the date the MCO notified the member of the grievance resolution determination.
Formula	Enter date in MM/DD/YYYY format. Note: This date must be January 1, 2005 or later. OMPP will calculate the total number of business days to resolution using the "Date Received" and "Date Resolved" data.
9. Business Days To Resolve	
Qualifications/ Definitions	Calculate the number of business days to resolve the member grievance from the date the grievance is received to the date the member was notified of the MCO decision.
Formula	This field will auto-fill.

TABLE MO-M2: Member Grievance Matrix

Issue	Final Policy
1. Definition of a grievance and an expedited grievance.	• A member or provider on behalf of a member may file a grievance orally or in writing. • A grievance is any dissatisfaction expressed by the member or a provider on behalf of a member of a MCO regarding the availability, delivery, appropriateness or quality of health care services and matters pertaining to the contractual relationship between an enrollee and a MCO or group individual contract holder for which the enrollee has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of the dissatisfaction. • An inquiry that is not resolved by the close of the next business day is considered a grievance. • An expedited grievance is defined as a grievance regarding an issue that would seriously jeopardize the life or health of a member or the member's ability to reach and maintain maximum function.
2. Timeframe for initial submission of a grievance or an expedited grievance.	• A member will have 60 calendar days from the day of the decision or event in question to file an oral or written grievance.
3. Timeframe for a MCO to acknowledge receipt of a grievance or an expedited grievance.	• The MCO must acknowledge receipt of an oral or written grievance within three calendar days after the grievance is filed.

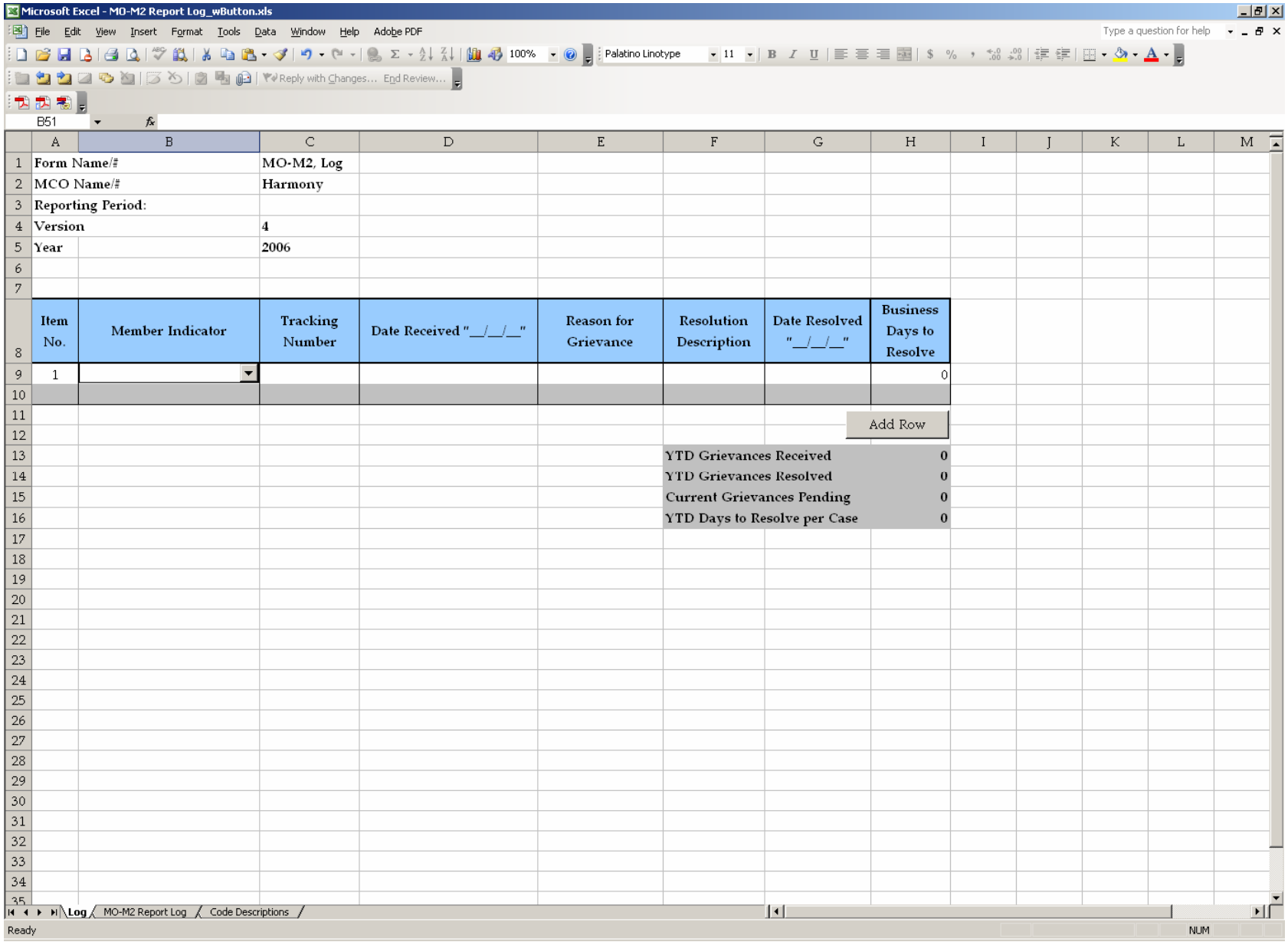
Issue	Final Policy
4. Timeframe for resolution of a grievance and an expedited grievance.	• The MCO must resolve a written or oral grievance as expeditiously as possible, but not more than 20 business days after a grievance is filed. • The grievance procedure must require an expedited grievance review if adhering to the 20 business day timeframe resolution would seriously jeopardize the life or health of a member or the member's ability to regain maximum function. • Expedited grievance reviews must be resolved within 72 hours of the MCO's receipt of the review request.
5. Extension of the grievance resolution timeframe.	• If the MCO is unable to make a decision regarding a grievance within the 20 business day period due to circumstances beyond its control, the MCO shall notify the member in writing of the reason for the delay within the 20 business day period. • The MCO then must make a decision regarding the grievance within 10 additional business days.
6. Notice of a resolution to the member.	• The MCO must respond in writing to an enrollee within five calendar days after resolution of the grievance. The resolution will include notice of the member's right to file an appeal.
7. Reporting requirement.	• Report monthly using the grievance reporting form. • Report separately for children with special health care needs and Package C members.

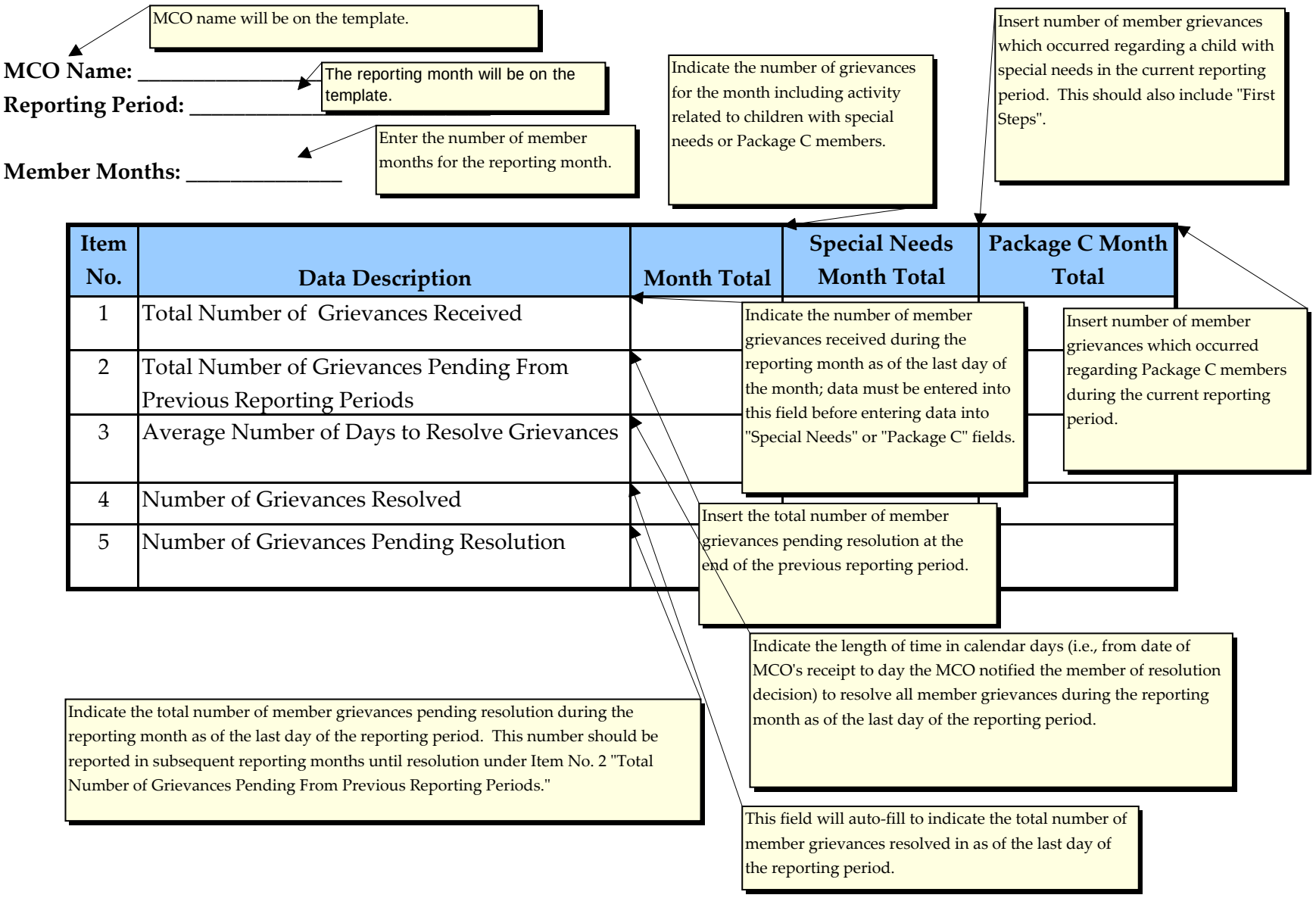


Microsoft Excel - MO-M2.xls

Form Name/#	MO-M2	
MCO Name/#	Harmony	
Reporting Period	January	
Version	4	
Year	2006	
Member Months	0	

Item No.	Data Description	Month Total	Special Needs Month Total	Package C Month Total
1	Total Number of Grievances Received	0	0	0
2	Total Number of Grievances Pending From Previous Reporting Periods	0	0	0
3	Average Number of Days to Resolve Grievances	0	0	0
4	Number of Grievances Resolved	0	0	0
5	Number of Grievances Pending Resolution	0	0	0


Microsoft Excel - MO-M2 Report Log_wButton.xls
File Edit View Insert Format Tools Data Window Help Adobe PDF
Type a question for help
Palatino Linotype 11
Reply with Changes... End Review...
B51
Form Name/# MO-M2, Log
MCO Name/# Harmony
Reporting Period:
Version 4
Year 2006
Item No.
Member Indicator
Tracking Number
Date Received "__/__/__"
Reason for Grievance
Resolution Description
Date Resolved "__/__/__"
Business Days to Resolve
1
0
Add Row
YTD Grievances Received 0
YTD Grievances Resolved 0
Current Grievances Pending 0
YTD Days to Resolve per Case 0
Log
MO-M2 Report Log
Code Descriptions
Ready
NUM


MCO name will be on the template.
MCO Name: _____
The reporting month will be on the template.
Reporting Period: _____
Enter the number of member months for the reporting month.
Member Months: _____
Indicate the number of grievances for the month including activity related to children with special needs or Package C members.
Insert number of member grievances which occurred regarding a child with special needs in the current reporting period. This should also include "First Steps".
Item No.
Data Description
Month Total
Special Needs Month Total
Package C Month Total
1 Total Number of Grievances Received
2 Total Number of Grievances Pending From Previous Reporting Periods
3 Average Number of Days to Resolve Grievances
4 Number of Grievances Resolved
5 Number of Grievances Pending Resolution
Indicate the number of member grievances received during the reporting month as of the last day of the month; data must be entered into this field before entering data into "Special Needs" or "Package C" fields.
Insert number of member grievances which occurred regarding Package C members during the current reporting period.
Insert the total number of member grievances pending resolution at the end of the previous reporting period.
Indicate the length of time in calendar days (i.e., from date of MCO's receipt to day the MCO notified the member of resolution decision) to resolve all member grievances during the reporting month as of the last day of the reporting period.
Indicate the total number of member grievances pending resolution during the reporting month as of the last day of the reporting period. This number should be reported in subsequent reporting months until resolution under Item No. 2 "Total Number of Grievances Pending From Previous Reporting Periods."
This field will auto-fill to indicate the total number of member grievances resolved in as of the last day of the reporting period.

MCO Name: _____

Reporting Period: _____

MCO name will be on the template.

Enter the last month for which the MCO is reporting member grievance data in MM/YYYY format.

Enter a brief reason description for each member grievance received during the month; limit to 100 alpha/numeric characters.

Item No.	Member Indicator	Tracking Number	Date Received	Reason for Grievance	Resolution Description	Date Resolved	Business Days To Resolve

This field will auto-fill for each member grievance listed.

Enter a tracking number (e.g., RID) for the member specific to the member.

Enter a brief description of the resolution decision; limit description to 200 alpha/numeric characters; leave blank if no decision was made as of the last day of the reporting period.

This field will auto-fill.

Select member indicator description from the menu.

Insert the date the MCO received the member grievance; enter in MM/DD/YYYY format.

Insert the date the MCO notified the member of the resolution decision; enter in DD/MM/YYYY format.

Member Indicator Descriptions

General member

Package C member

Special needs member

General Report Description	
MO-M3 Member Appeals	
Purpose	Monitor the volume and timely resolution of the MCO's member appeals monthly, identifying member appeal activity related to children with special needs and Package C members separately.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a monthly report. The MCO must submit the report to the monitoring contractor and OMPP by the 15th day of the month following the end of the reporting period. At OMPP's discretion, the MCO may submit monthly data on a quarterly basis by the last day of the month following the end of the reporting quarter. The MCO must identify data for children with special needs and Package C members separately in the report. Special needs children should also include "First Steps" members. The MCO must refer to Table MO-M3: Member Appeals Matrix (attached) for more information on the member appeals policy, definitions and timelines. OMPP is providing one template for each month of the year. The MCO must submit its data using the appropriately named template. For example, MO-M3_Apr_06.xls is the template name for April's data.
Performance Measures	The MCO should resolve member appeals within 30 business days of receipt.
MO-M3 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting period for which member appeal data is being submitted.
Formula	This field will auto-fill.

2. Total Number of Appeals Received	
Qualifications/ Definitions	Enter the number of member appeals received (including those from children with special needs and Package C members) during the reporting month as of the last day of the reporting period. Also, indicate the number of member appeals received during the reporting month for children with special needs and Package C members each separately.
Formula	Enter total numbers. Note: Enter number into the "Month Total" field before entering data into the "Special Needs Month Total" or "Package C Month Total" fields. OMPP will calculate member appeals by 1,000 member months and calculate year-to-date activity from monthly data.
3. Total Number of Appeals Pending From Previous Reporting Periods	
Qualifications/ Definitions	Insert the total number of member appeals pending resolution (including those from children with special needs and Package C members) at the end of the previous reporting period. Also, identify the total number of member appeals pending a resolution regarding children with special needs and Package C members each separately.
Formula	Enter total numbers. OMPP will calculate year-to-date activity using monthly data.
4. Average Number of Days to Resolve Appeals	
Qualifications/ Definitions	Calculate resolution times in business days from the date the MCO received the member appeal to the day the MCO notified the member of a resolution determination.
Formula	Calculate the number of business days. OMPP will calculate year-to-date activity using monthly data.

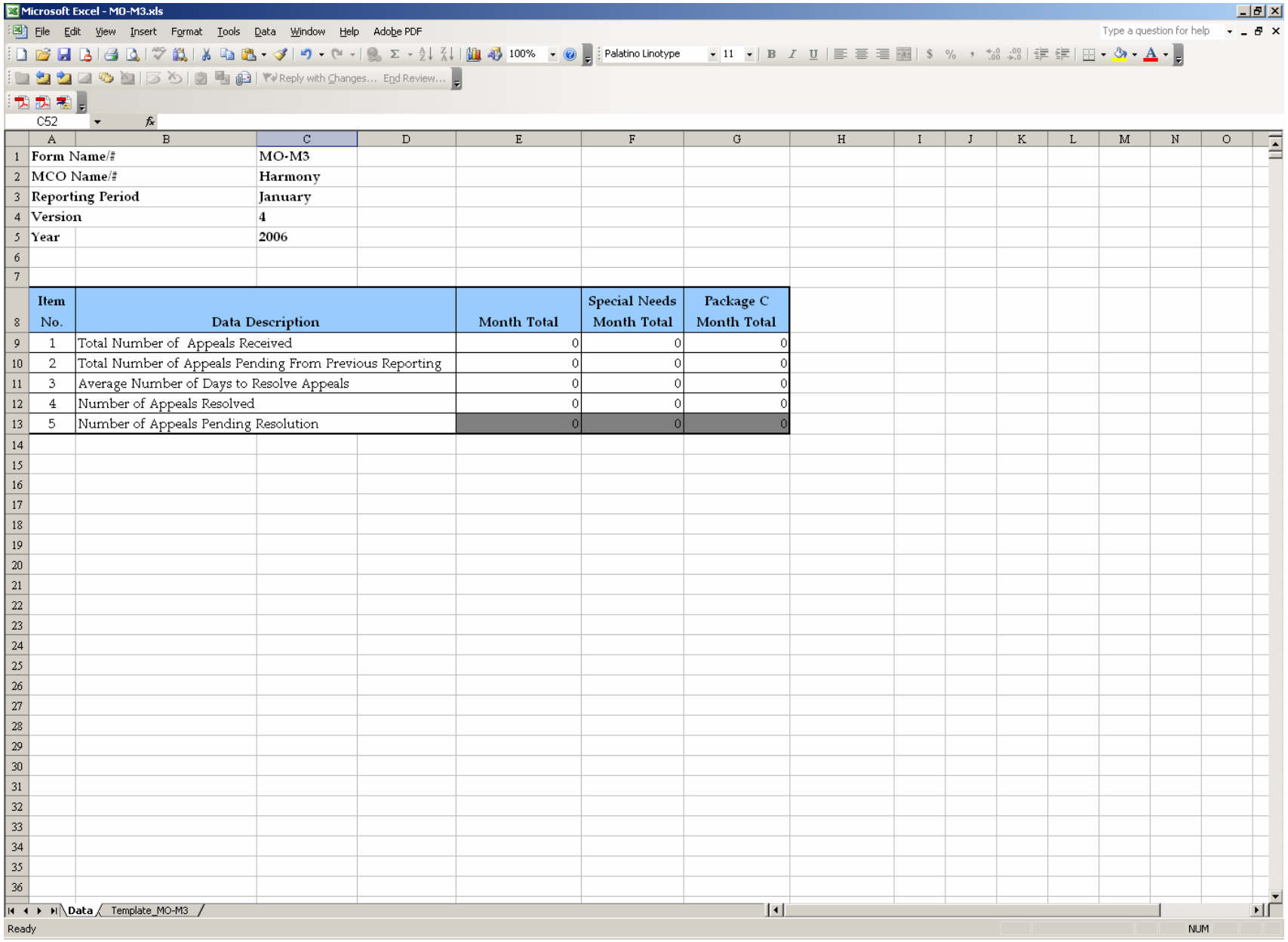
5. Number of Appeals Resolved	
Qualifications/ Definitions	Identify the total number of member appeals (including those from children with special needs and Package C members) that were resolved during the reporting month as of the last day of the reporting period. Also, indicate the number of member appeals resolved during the reporting month for children with special needs and Package C members each separately.
Formula	This number will auto-fill. OMPP will calculate year-to-date activity from monthly data.
6. Number of Appeals Pending Resolution	
Qualifications/ Definitions	Identify the total number of member appeals pending resolution (including those from children with special needs and Package C members) at the end the reporting period as of the last day of the reporting period. Also, indicate the number of member appeals pending resolution at the end of the reporting period for children with special needs and Package C members each separately.
Qualifications/ Definitions (Continued)	In subsequent reports, this number should be reported until a resolution is determined under Item Number 3: "Total Number of Appeals Pending From Previous Reporting Periods."
Formula	This field will auto-fill by calculating (number received + number pending from previous) – number resolved. OMPP will calculate year-to-date activity from monthly data.
MO-M3 Report Log Data Elements	
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a monthly report log that supplements the Member Appeals (MO-M3) Report. The MCO must submit the report to the monitoring contractor and OMPP by the 15th day of the month following the end of the reporting period. At OMPP's discretion, the MCO may submit monthly data on a quarterly basis by the last day of the month following the end of the reporting quarter. The MCO should submit a report log each reporting period using the previous reporting period's log but updated with the current reporting period's member appeal activity. The report log must include all member appeals from reporting period to reporting period until the MCO completes the appeal process.

1. Reporting Period	
Qualifications/ Definitions	Enter the last month for which the MCO is reporting member appeal data.
Formula	Enter in MM/YYYY format.
2. Item No.	
Qualifications/ Definitions	Consecutively number all member appeals received, resolved or pending resolution during the reporting period.
Formula	This field will auto-fill to consecutively number all member appeals listed.
3. Member Indicator	
Qualifications/ Definitions	Indicate the type of member using the indicator descriptions below: <u>Member Indicator Descriptions</u> General member Package C member Special needs member
Formula	Enter member type from the menu.
4. Tracking Number	
Qualifications/ Definitions	Provide a unique tracking number for the member. The MCO may use the recipient identification number (RID) but must use the same unique tracking number for this member throughout the grievance and appeal process related to this specific issue. The tracking number can be the RID or any alpha/numeric code that the MCO assigns to the member for the purposes of reporting <u>all</u> member grievances and appeals related to one individual.
Formula	Limit the MCO-determined tracking number to 25 alpha/numeric characters.
5. Date Received	
Qualifications/ Definitions	Identify the date the MCO received the member appeal for all member appeals received, resolved or pending response during the reporting month.
Formula	Enter date in MM/DD/YYYY format. Note: This date must be January 1, 2005 or later.

6. Reason for Appeal	
Qualifications/ Definitions	Identify a brief reason for each member appeal received during the reporting month.
Formula	Limit 100 alpha/numeric characters.
7. Resolution Description	
Qualifications/ Definitions	If a resolution was made during the reporting period, enter a brief description of the resolution determination in narrative text. A resolution is considered complete when the MCO notifies the member of the resolution decision. If the resolution decision was not communicated to the member by the last day of the reporting period, leave this field blank and include this member appeal in subsequent reports until a resolution is complete.
Formula	Limit to 200 alpha/numeric characters.
8. Date Resolved	
Qualifications/ Definitions	Identify the date the MCO notified the member of the appeal resolution determination.
Formula	Enter date in MM/DD/YYYY format. Note: This date must be January 1, 2005 or later. OMPP will calculate the total number of business days to resolution using the "Date Received" and "Date Resolved" data.
9. Business Days To Resolve	
Qualifications/ Definitions	Calculate the number of business days to resolve the member appeal from the date the appeal is received to the date the member was notified of the MCO decision.
Formula	This field will auto-fill.

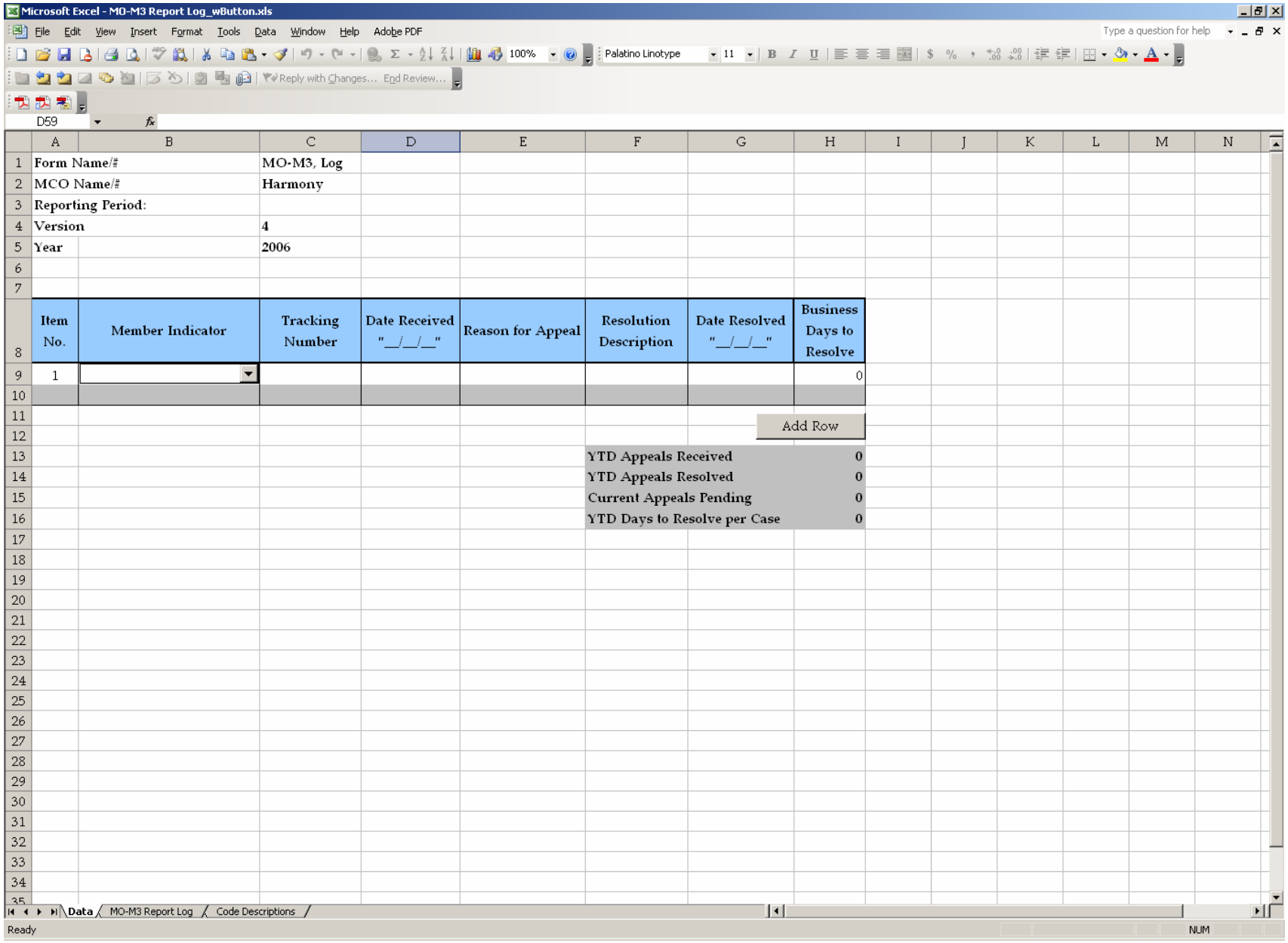
TABLE MO-M3: Member Appeal Matrix

Issue	Final Policy
1. Definition of an appeal and an expedited appeal.	• An appeal is a written request from a member or a provider on the behalf of the member to change a previous decision made by a MCO. • An expedited appeal review is defined as an issue that would seriously jeopardize the life or health of a member or the member's ability to regain maximum function.
2. Timeframe for submission of an appeal or an expedited appeal.	• A member will have 30 calendar days from the day of the decision in question to file an appeal.
3. Timeframe for a MCO to acknowledge receipt of an appeal or an expedited appeal.	• The MCO must acknowledge in writing the receipt of an appeal within three business days after the request for an appeal is received.
4. Timeframe for resolution of a standard appeal or expedited appeal.	• An appeal must be resolved as expeditiously as possible with regard to the clinical urgency of the appeal. However, an appeal must be resolved within 30 business days. • An expedited appeal review must be conducted within 72 hours of the MCO's receipt of the review request.
5. Extension of the appeal resolution timeframe.	• If the MCO is unable to resolve the appeal within 30 business days because of circumstances beyond its control, the MCO must notify the member on or before day 30 that it requires more time to complete the process.



Form Name/#		MO-M3
MCO Name/#		Harmony
Reporting Period		January
Version		4
Year		2006

Item No.	Data Description	Month Total	Special Needs Month Total	Package C Month Total
1	Total Number of Appeals Received	0	0	0
2	Total Number of Appeals Pending From Previous Reporting	0	0	0
3	Average Number of Days to Resolve Appeals	0	0	0
4	Number of Appeals Resolved	0	0	0
5	Number of Appeals Pending Resolution	0	0	0



Microsoft Excel - MO-M3 Report Log_wButton.xls

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	Form Name/#		MO-M3, Log											
2	MCO Name/#		Harmony											
3	Reporting Period:													
4	Version		4											
5	Year		2006											
6														
7														
8	Item No.	Member Indicator	Tracking Number	Date Received "__/__/__"	Reason for Appeal	Resolution Description	Date Resolved "__/__/__"	Business Days to Resolve						
9	1							0						
10														
11														
12								Add Row						
13						YTD Appeals Received		0						
14						YTD Appeals Resolved		0						
15						Current Appeals Pending		0						
16						YTD Days to Resolve per Case		0						

MCO name will be on the template.

MCO Name: _____

The reporting month will be on the template.

Reporting Period: _____

Insert number for member appeals which occurred regarding a child with special needs in the current reporting period.

Indicate the number of appeals for the month including activity related to children with special needs or Package C members.

Item No.	Data Description	Month Total	Special Needs Month Total	Package C Month Total
1	Total Number of Appeals Received			
2	Total Number of Appeals Pending From Previous Reporting Periods			
3	Average Number of Days to Resolve Appeals			
4	Number of Appeals Resolved			
5	Number of Appeals Pending Resolution			

Indicate the number of member appeals received during the reporting month as of the last day of the month; data must be entered into this field before entering data into "Special Needs" or "Package C" fields.

Insert number for member appeals which occurred regarding Package C members during the current reporting period.

Insert the total number of member appeals pending resolution at the end of the previous reporting period.

Indicate the total number of member appeals pending resolution during the reporting month as of the last day of the reporting period. This number should be reported in subsequent reporting months until resolution under Item No. 2 "Total Number of Appeals Pending From Previous Reporting Periods."

Indicate the length of time in business days (i.e., from date of MCO's receipt to day the MCO notified the member of resolution decision) to resolve all member appeals during the reporting month as of the last day of the reporting period.

This number will auto-fill to indicate the total number of member appeals resolved in as of the last day of the reporting period.

MCO Name: _____

MCO name will be on the template.

Reporting Period: _____

Enter the last month for which the MCO is reporting member appeal data in MM/YYYY format.

Enter a brief description of the resolution decision; limit description to 200 alpha/numeric characters; leave blank if no decision was made as of the last day of the reporting period.

Item No.	Member Indicator	Tracking Number	Date Received	Reason for Appeal	Resolution Description	Date Resolved	Business Days To Resolve

This field will auto-fill to consecutively number all member appeals listed.

Select member indicator description from the menu.

Insert the date the MCO received the member appeal; enter in MM/DD/YYYY format.

Insert the date the MCO notified the member of the resolution decision; enter in MM/DD/YYYY format.

Enter a brief reason description for each member appeal received during the month; limit to 100 alpha/numeric characters.

Enter a tracking number (e.g., RID) for the member specific to the member and consistent for that member in all member grievance and appeal activities related to this appeal.

This field will auto-fill.

Member Indicator Descriptions

General member

Package C member

Special needs member

General Report Description	
QR-M1 FSSA Hearings and Appeals	
Purpose	Monitor the number and timely resolution of member requests for FSSA hearings during the reporting period.
Required Submission Type	Excel template.
Comments/ Recommendations	This is an ad-hoc quarterly report. The MCO must submit this report to the monitoring contractor and OMPP within five (5) business of knowing about the appeal. Subsequently, the MCO must submit a quarterly report by the last day of the month following the end of the reporting calendar quarter in which the initial report was submitted to OMPP with additional quarterly reports until the appeal is reported as 'resolved'. Resolution is determined from the date the MCO receives the review request to the date FSSA informs the member of the resolution decision (i.e., date FSSA mailed the resolution notice to the member or date FSSA verbally notified the member and the FSSA documented that notification date in its member grievance files).
Performance Measures	OMPP has not indicated specific performance measures at this time.
QR-M1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting quarter for which FSSA hearings' data is being submitted.
Formula	Enter the reporting period.
2. Item No.	
Qualifications/ Definitions	Consecutively number all member grievances received, resolved or pending resolution during the reporting period.
Formula	Number consecutively all member grievances listed beginning with number 1.

3. Tracking Number	
Qualifications/ Definitions	Provide a unique tracking number for the member. The MCO may use the recipient identification number (RID) but must use the same unique tracking number for this member throughout the grievance and appeal process related to this specific issue. The tracking number can be the RID or any alpha/numeric code that the MCO assigns to the member for the purposes of reporting <u>all</u> member grievances and appeals related to one individual.
Formula	Limit the MCO-determined tracking number to 25 alpha/numeric characters.
4. Date Received	
Qualifications/ Definitions	Identify the date FSSA and MCO received the member's request for a FSSA hearing.
Formula	Enter date in MM/DD/YY format.
5. Reason for Hearing	
Qualifications/ Definitions	Briefly describe the reason(s) the member requested the FSSA hearing.
Formula	Limit to 100 alpha/numeric characters.
6. Resolution Status	
Qualifications/ Definitions	Identify the status of the member's request for the FSSA hearing as of the last day of the reporting period using the status descriptions below: <u>Status Descriptions</u> A resolution decision was rendered in favor of the member A resolution decision was rendered in favor of the MCO A resolution decision was pending If the resolution decision has not been communicated to the member as of the last day of the reporting period, the hearing decision is considered pending and the member request should be included in subsequent reports until resolved (i.e., member is notified).
Formula	Enter a resolution status description from the code descriptions menu.

7. Resolution	
Qualifications/ Definitions	If a resolution decision was rendered in "Resolution Status", enter a brief description of the decision rendered. If the member was not notified of FSSA's decision at the end of the reporting period (i.e., a resolution decision was pending), leave this field blank.
Formula	Limit descriptions to 200 alpha/numeric characters.
8. Resolution Date	
Qualifications/ Definitions	Indicate the date the member was notified of FSSA's decision.
Formula	Enter date in MM/DD/YY format. OMPP will calculate the calendar days to resolution using the "Date Received" and "Resolution Date" data.

MCO Name: _____

Enter MCO name on the template.

Reporting Period: _____

Enter the reporting period.

Item No.	Tracking Number	Date Received	Reason for Hearing	Resolution Status	Resolution	Resolution Date

Consecutively number each hearing request received, resolved or pending resolution this reporting period beginning with the number 1.

Enter the date the FSSA received the member request for an appeal hearing in MM/DD/YY format.

As of the last day of the reporting period, enter the resolution status description from the code description menu.

If resolved, enter a brief description of the resolution decision; limit description to 200 alpha/numeric characters.

Enter a brief description of the reason for the member's request for a hearing; limit to 100 alpha/numeric characters.

Enter a tracking number (e.g., RID) for the member specific to the member and consistent for that member in all member grievance and appeal activities related to this hearing request.

Enter the date the member was notified of FSSA's decision; enter in MM/DD/YY format.

Resolution Status Descriptions

A resolution decision was rendered in favor of the member.
A resolution decision was rendered in favor of the MCO.
A resolution decision was pending.

General Report Description	
AN-M1 Consumer Assessment of Health Plans Survey (CAHPS®) Summary	
Purpose	Assess and document the experiences members report with their managed care organization as an indicator of quality of various aspects of care and customer service.
Required Submission Type	Submission type will be determined by OMPP prior to the MCO conducting the survey.
Comments/ Recommendations	This is an annual report. The MCO must submit this report to the monitoring contractor and OMPP by July 31st with the second quarter's non-financial report submission. Historically, OMPP has modeled its survey tool on the National Committee for Quality Assurance (NCQA) Consumer Assessment of Health Plans Study (CAHPS®) survey tool. The MCO can find additional information about this survey tool and NCQA's nationally standardized reporting methodology on the NCQA website at: http://www.ncqa.org.
Performance Measures	OMPP has not indicated specific performance measures at this time.
AN-M1 Data Elements	
1. All Data Elements	
Qualifications/ Definitions	OMPP will specify any additional data elements prior to the MCO's developing its survey questions.
Formula	OMPP has not indicated a formula at this time.

General Report Description	
QR-N1 Promotional, Educational, Outreach and Incentive Materials Inventory and Distribution	
Purpose	Identify and list the types of promotional, educational, outreach and incentive materials that the MCO has available to use, has used or anticipates developing for use during the calendar quarter to communicate Hoosier Healthwise program-related issues regarding clinical, technical, services or health care benefits to providers, members or the general Hoosier Healthwise community.
Required Submission Type	Excel template.
Comments/ Recommendations	The MCO must maintain a complete list of its promotional, educational, outreach and incentive materials current inventory and identify materials it anticipates developing during the calendar year in the first quarter's report. The MCO should update the list and distribution information each subsequent calendar quarter. This list is not submitted to the monitoring contractor but must be available for OMPP review during on-site monitoring. OMPP prefers the MCO use the Excel template provided with this report description but will allow the MCO to use any format that includes all the required elements described below. All promotional, educational, outreach and incentive materials must be approved by OMPP before use. The MCO should update this list each time it submits materials for OMPP's approval. The MCO should review its promotional, educational, outreach and incentive materials at least annually to maintain the currency of the information provided in the materials.
Performance Measures	The MCO must receive OMPP's approval on all promotional, educational, outreach and incentive materials 30 calendar days prior to the MCO's distribution or use.
QR-N1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the calendar quarter in which the MCO distributed, developed or anticipated developing any promotional, educational, outreach and incentive materials for members, providers or general Hoosier Healthwise community.
Formula	Enter the calendar quarter.

2. Item No.	
Qualifications/ Definitions	Consecutively number all promotional, educational, outreach and incentive materials the MCO has available to use or anticipates developing for use.
Formula	Consecutively number each material listed beginning with number 1.
3. Material Catalogue Number	
Qualifications/ Definitions	Create and enter an identification number (i.e., inventory control number) for the material item that the MCO used, had available to use or anticipates developing for use during the reporting quarter. This number should be consistently used for the individual material item each reporting quarter and throughout the reporting calendar year. If a material item is anticipated for development and does not have a catalogue number assigned as of the time of the report, the MCO should leave this field blank. If an item is discontinued from use during the calendar year, the MCO should retire the catalogue number from use until the next calendar year's first quarter report.
Formula	MCO's choice but OMPP prefers limiting catalogue number to 25 alpha/ numeric characters.
4. Title	
Qualifications/ Definitions	Identify each material using a descriptive name that may be referenced in other MCO materials or reports.
Formula	MCO's choice but OMPP prefers limiting title to 50 alpha/numeric characters.
5. Topic	
Qualifications/ Definitions	Identify the topic discussed in the informational materials.
Formula	MCO's choice but OMPP prefers limiting topic descriptions to 100 alpha/ numeric characters.

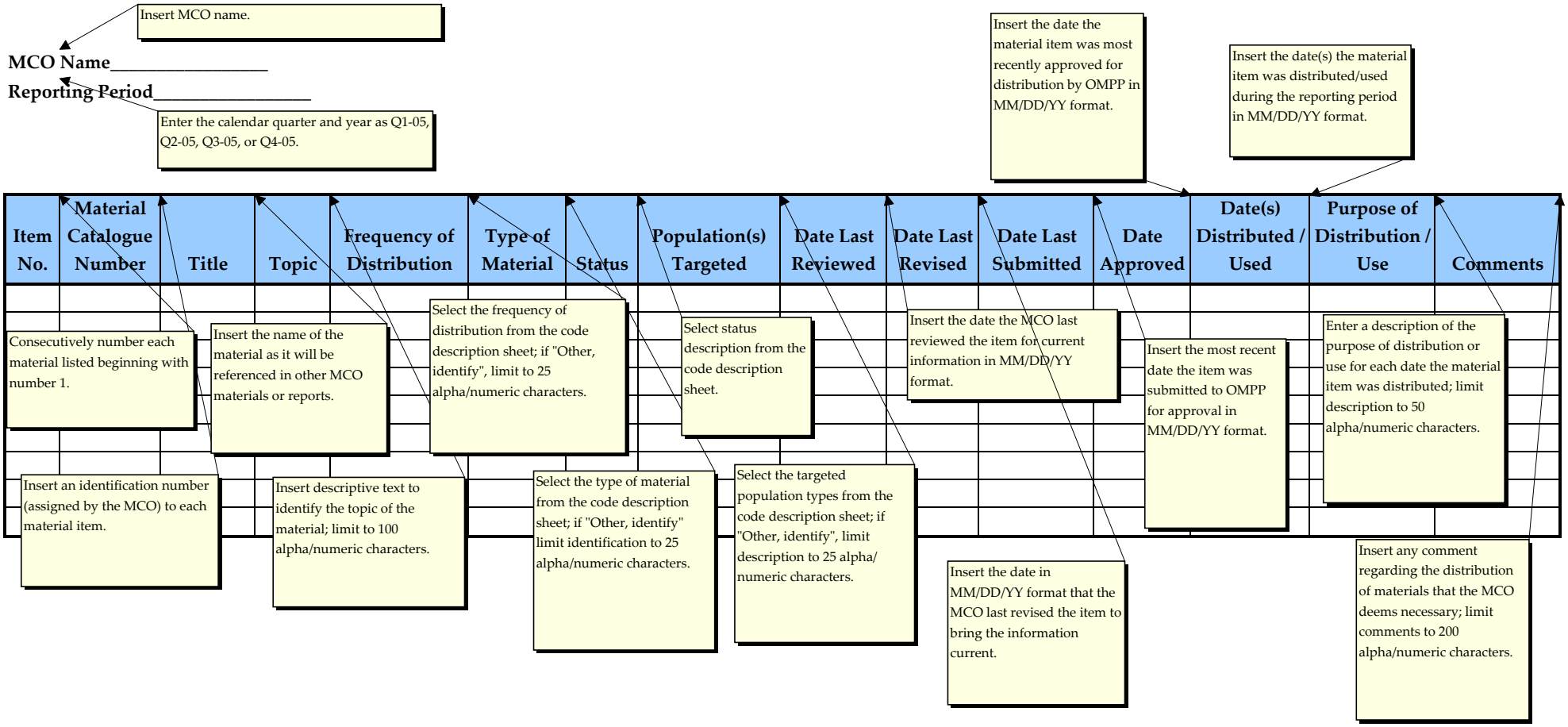
6. Type of Material	
Qualifications/ Definitions	Identify the type of promotional, educational, outreach or incentive materials that the MCO has available for use, used or anticipates developing for use during the reporting period using the descriptions below: <u>Types of Materials</u> Alternate Language Packets/Materials Audio Visual Materials (CD, VHS, DVD) Community Donations Disease Management Materials Enhanced Services Informational/Educational Materials Enhanced Services Incentive Items General Member Materials General Provider Materials Give-away Items (pens, magnets, key chains, etc.) Instruction Sheet (Member or Provider) Letter Member Handbook New Member Packet Newsletter (Member or Provider) Other, identify Posters Promotional Packet Provider Directory Provider Manual/Supplement Questionnaire/Survey
Formula	Enter the type of material from the menu; if "Other, identify", limit identification to 25 alpha/numeric characters.

7. **Frequency of Distribution**	
Qualifications/ Definitions	Identify the frequency of distribution that the MCO anticipated when developing each material item(s) by the frequency descriptions below: <u>Frequency of Distribution</u> Annually Bi-monthly Monthly Not Applicable Ongoing Other, identify Periodic Quarterly Semi-annually Upon request
Formula	Enter the appropriate description from the menu; if "Other, identify", limit description to 25 alpha/numeric characters.
8. **Status**	
Qualifications/ Definitions	Identify the status of the material item(s) as of the last day of the reporting period using the descriptions below. The MCO should identify one status code for each material item listed on the report as follows: <u>Status Descriptions</u> A = Active and approved by OMPP R = Retired, previously approved by OMPP but no longer anticipated being used by the MCO during the calendar year P = Pending OMPP's approval at the time this report is submitted
Formula	Enter the appropriate status description from the menu.

9. Population(s) Targeted	
Qualifications/ Definitions	Identify the type of population that the promotional, educational, outreach and incentive material item(s) target by using the descriptions types below. The MCO may indicate more than one target population type for each material. <u>Type of Provider Population</u> Chiropractor Clinics/Health Department (not FQHC/RHC) Durable Medical Equipment Family Planning FQHC/RHC Home Health Hospital Laboratory Optometrist Other, identify (specialist physicians, other providers) Pharmacy Physician, PMP Podiatrist Transportation <u>Type of Member Populations</u> Advocates All Members Disease Management - Asthma Disease Management - Other Member(s) and Member Representatives Multiple Selections Other, identify Pregnant Women Special Needs Members
Formula	Enter the appropriate population type from the menu; if "Other, identify", limit to 25 alpha/numeric characters.

10. Date Last Reviewed	
Qualifications/ Definitions	Identify the date the material item was last reviewed by the MCO.
Formula	Enter date in MM/DD/YY format.
11. Date Last Revised	
Qualifications/ Definitions	Identify the date the material item was last revised by the MCO; this date should be before the "Date Last Submitted" by the MCO.
Formula	Enter the date in MM/DD/YY format.
12. Date Last Submitted	
Qualifications/ Definitions	Identify the date that the MCO last submitted the material item to OMPP for approval. This date should be after the "Date Last Revised" by the MCO.
Formula	Enter date in MM/DD/YY format.
13. Date Approved	
Qualifications/ Definitions	Enter the date of the material item was approved by OMPP; this date should be after the "Date Last Submitted" by the MCO.
Formula	Enter the date in MM/DD/YY format.
14. Date(s) Distributed/Used	
Qualifications/ Definitions	Enter the date(s) the material item was distributed or used during the reporting quarter. If the material item listed was not distributed or used during the reporting period, leave this field blank.
Formula	Enter the date in MM/DD/YY format.
15. Purpose of Distribution/Use	
Qualifications/ Definitions	Provide a brief description of the reason the material item was distributed or used (e.g., annual membership distribution, health fair, member education, outreach seminar, etc) for each date listed during the reporting quarter. If the material item listed was not distributed or used during the reporting period, leave this field blank.
Formula	Limit comments to 50 alpha/numeric characters.

15. Comments	
Qualifications/ Definitions	Provide further comments regarding the material item(s) as the MCO deems necessary.
Formula	Limit comments to 200 alpha/numeric characters.


Insert MCO name.
MCO Name_____
Reporting Period_____
Enter the calendar quarter and year as Q1-05, Q2-05, Q3-05, or Q4-05.
Insert the date the material item was most recently approved for distribution by OMPP in MM/DD/YY format.
Insert the date(s) the material item was distributed/used during the reporting period in MM/DD/YY format.
Item No.
Material Catalogue Number
Title
Topic
Frequency of Distribution
Type of Material
Status
Population(s) Targeted
Date Last Reviewed
Date Last Revised
Date Last Submitted
Date Approved
Date(s) Distributed / Used
Purpose of Distribution / Use
Comments
Consecutively number each material listed beginning with number 1.
Insert the name of the material as it will be referenced in other MCO materials or reports.
Select the frequency of distribution from the code description sheet; if "Other, identify", limit to 25 alpha/numeric characters.
Select status description from the code description sheet.
Insert the date the MCO last reviewed the item for current information in MM/DD/YY format.
Insert the most recent date the item was submitted to OMPP for approval in MM/DD/YY format.
Enter a description of the purpose of distribution or use for each date the material item was distributed; limit description to 50 alpha/numeric characters.
Insert an identification number (assigned by the MCO) to each material item.
Insert descriptive text to identify the topic of the material; limit to 100 alpha/numeric characters.
Select the type of material from the code description sheet; if "Other, identify" limit identification to 25 alpha/numeric characters.
Select the targeted population types from the code description sheet; if "Other, identify", limit description to 25 alpha/ numeric characters.
Insert the date in MM/DD/YY format that the MCO last revised the item to bring the information current.
Insert any comment regarding the distribution of materials that the MCO deems necessary; limit comments to 200 alpha/numeric characters.

Type of Materials	Frequency of Distribution	Type of Provider Population	Type of Member Population
Alternate Language Packets / Materials	Annually	Chiropractor	Advocates
Audio Visual Materials (CD, VHS, DVD)	Bi-monthly	Clinics / Health Department (not FQHC / RHC)	All Members
Community Donations	Monthly	Durable Medical Equipment	Disease Management - Asthma
Disease Management Materials	Not applicable	Family Planning	Disease Management - Other
Enhanced Services Informational Materials	Ongoing	FQHC / RHC	Member(s) and Member Representatives
Enhanced Services Incentive Items	Periodic	Home Health	Multiple Selections
General Member Materials	Other, identify	Hospital	Other, identify
General Provider Materials	Quarterly	Laboratory	Pregnant Women
Give-away Items (pens, magnets, key chains, etc.)	Semi-annually	Optometrist	Special Needs Members
Instruction Sheet (Member or Provider)	Upon request	Other, identify (specialist physicians, other providers)	
Letter		Pharmacy	
Member Handbook / Supplement		Physician, PMP	
New Member Packet		Podiatrist	
Member Newsletter		Transportation	
Other, identify	Status Description		
Posters	A = Active and approved by OMPP		
Promotional Packet	R = Retired, previously approved by OMPP but no longer anticipated being used by the MCO during the calendar year		
Provider Manual / Supplement	P = Pending OMPP's approval at the time this report is submitted		
Provider Directory			
Questionnaire / Survey			

General Report Description	
AN-N1 Network Geographic Access Assessment	
Purpose	Confirm that the MCO's members have access to needed health care services within reasonable travel times based on the proximity of the members' residential zip code to the providers' office location zip code.
Required Submission Type	MCO's choice of format.
Comments/ Recommendations	This is an annual report. The MCO must submit this report to the monitoring contractor and OMPP by January 31st. The MCO may supply the information to satisfy the Performance Measures outlined below in the MCO's choice of format and must also report data regarding the number of PMP referrals made for the MCO's members to receive care from out-of-network providers by the member's county of residence and the type of provider to which the member was referred.
Performance Measures	Primary Medical Providers (PMP) • Panel size in mandatory risk-based managed care (RBMC) counties averaging 250 members to 1 PMP (i.e., 250:1) Specialty Providers • Two specialty providers for each mandatory type of provider in: - The member's county of residence, or - One specialty provider in the member's county of residence and one specialty provider in a contiguous county, or - One specialty provider in the member's county of residence and one specialty provider's office within 60 miles or 60 minutes drive time from the member's residence zip code Durable Medical Equipment and Home Health providers • One provider of each type must be available to provide services to the MCO's members in each of the mandatory RBMC counties Pharmacy providers • Two pharmacy providers must be within 30 miles or 30 minutes drive time from a member's residence in each of the mandatory RBMC counties

AN-N1 Data Elements	
1. All Data Elements	
Qualifications/ Definitions	Provide data showing a summary of provider locations for each mandatory provider type relevant to the MCO's members' residence zip code and county of residence. Provide data for the number of PMP referrals made for members to out-of-network providers by the member's county of residence and the type of provider to which the member was referred.
Formula	Members' residential zip code or county of residence to provider's office location or zip code.

General Report Description	
AN-N2 Provider Directory	
Purpose	Confirm that the MCO's members and the enrollment broker have information related to the health care providers and services within the MCO's network as described in 42 CFR 438.10 (e).
Required Submission Type	Excel template.
Comments/ Recommendations	This is an annual report. The MCO must submit this report to the monitoring contractor and OMPP by January 31st. At its discretion, OMPP may request supplemental reports throughout the reporting year. The MCO may add as many lines to the Excel template to permit including information for all the MCO's network providers.
Performance Measures	OMPP has not identified any performance measures at this time.
AN-N2 Data Elements	
1. Item No.	
Qualifications/ Definitions	Consecutively number each provider and provider location listed on the report.
Formula	Indicate a consecutive number for each provider or provider location listed beginning with number 1.
2. Provider Type	
Qualifications/ Definitions	Enter the provider type from the provider types listed below: <u>Provider Types</u> Chiropractor Clinics/Health Department (not FQHC/RHC) Durable Medical Equipment FQHC/RHC Home Health Hospital Laboratory Optometrist (Continued on the next page.)

Qualifications/ Definitions (Continued)	(Continued from the previous page.) Other, identify Pharmacy PMP General Practice PMP Family Practice PMP General Pediatrics PMP General Internal Medicine PMP Obstetrics/Gynecology Podiatrist Specialist Physician, identify Therapist, identify
Formula	Enter the provider type listed; if "Other, identify" limit description to 25 alpha/numeric characters.
3. Provider ID Number	
Qualifications/ Definitions	Identify the Medicaid identification number assigned to the listed provider by the State of Indiana.
Formula	Enter the Medicaid identification number.
4. Provider Last Name	
Qualifications/ Definitions	Enter the individual provider's officially recognized (legal) last name. This should not be a physician group name. If the provider is a facility or ancillary provider, enter the officially recognized name of the company or organization. If the provider has more than five service locations (e.g., pharmacy chains), list the provider once with a primary service location and indicate the multiple service locations by entering multiple counties.
Formula	Enter the individual provider's last name with the first letter of the name capitalized, or the officially recognized company or organization name of the ancillary or facility provider.
5. Provider First Name	
Qualifications/ Definitions	Identify the provider's officially recognized (legal) first name. If the provider is a facility or ancillary provider, leave this field blank.
Formula	Enter the individual provider's first name with the first letter of the name capitalized; leave the field blank if the provider is a facility or ancillary provider.

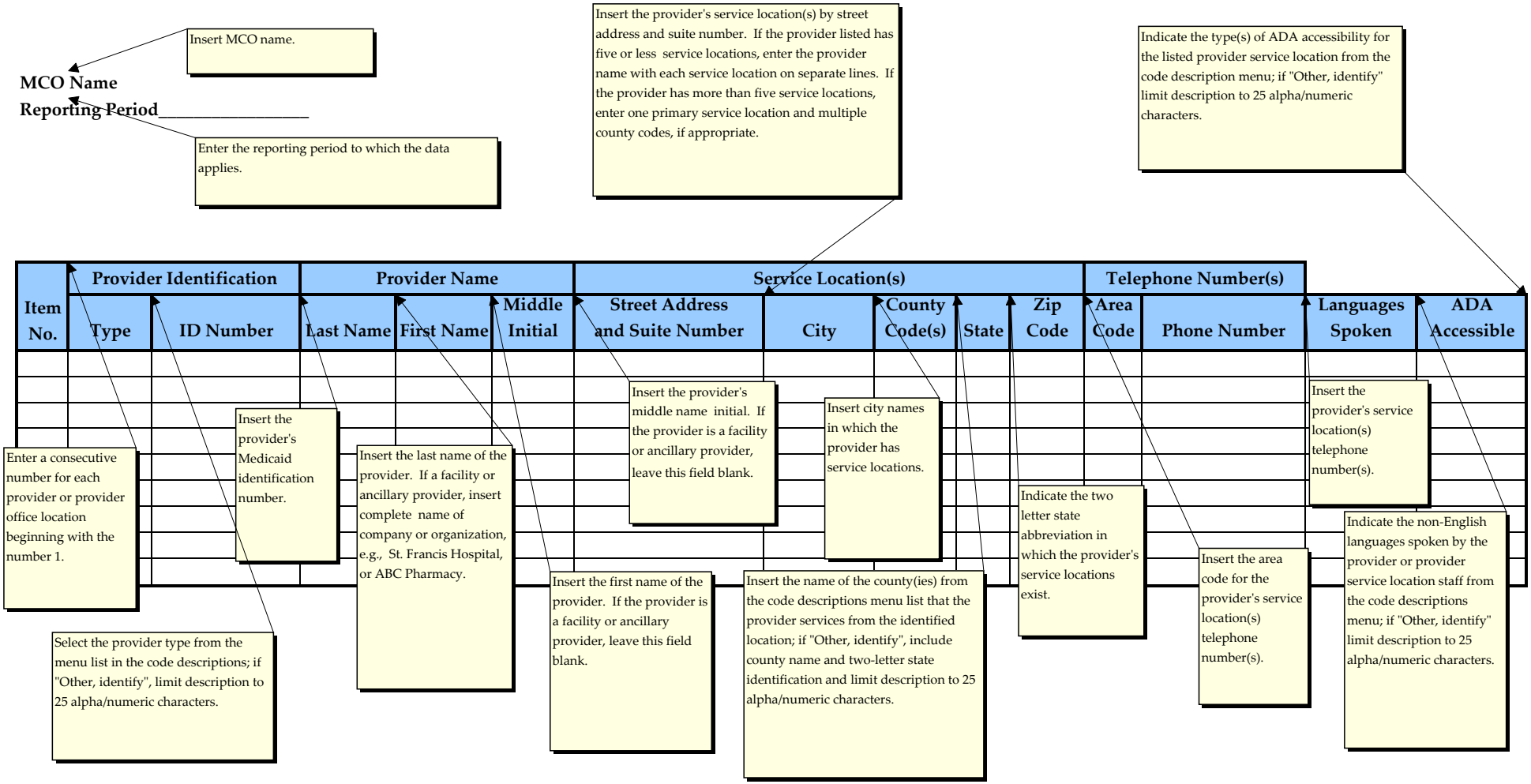
6. Provider Middle Initial	
Qualifications/ Definitions	Identify the provider's officially recognized (legal) middle name's first initial. If the provider is a facility or ancillary provider, leave this field blank.
Formula	Enter the individual provider's middle name initial with a capital letter; leave the field blank if the provider is a facility or ancillary provider.
7. Service Location Street Address and Suite Number	
Qualifications/ Definitions	Identify the street number, street name and suite number for each service location in which the listed provider renders services to Hoosier Healthwise members. If the provider has five or less service locations, enter the provider name with each service location on separate lines. If the provider has more than five service locations (e.g., pharmacy chains), list the provider once with a primary service location and indicate the multiple service locations by entering multiple county codes in one field.
Formula	Enter the street number, street name and suite number for each service location with each word starting with a capital letter or Arabic numeral (e.g., 135 Simpson Street, Suite 450).
8. City	
Qualifications/ Definitions	Identify the city, town or municipality for each provider service location listed.
Formula	Enter the city, town or municipality name beginning with a capital letter.
9. County Code	
Qualifications/ Definitions	Identify the county code for each provider service location by the county codes listed in Table AN-N2: County Listing (attached). If one provider service location provides services to multiple counties, enter multiple county codes in one field, separated by commas.
Formula	Enter the county code; if "Other, identify", enter the county code and the two-letter state abbreviation and limit description to 25 alpha/numeric characters.
10. State	
Qualifications/ Definitions	Identify the state for each provider service location listed.
Formula	Enter the two-letter state abbreviation recognized by the United States Post Office.

11. Zip Code	
Qualifications/ Definitions	Identify the mailing (i.e., zip) code for the provider service location listed.
Formula	Enter the five-digit mailing (i.e., zip) code recognized by the United States Post Office.
12. Telephone Area Code	
Qualifications/ Definitions	Identify the dialing area code for each of the provider's service locations listed.
Formula	Enter the three-digit area code (e.g., 317).
13. Telephone Number	
Qualifications/ Definitions	Identify the telephone number for each of the provider's service locations listed.
Formula	Enter the seven-digit telephone number (e.g., 222-5555)
14. Languages Spoken	
Qualifications/ Definitions	Identify all the non-English languages in which the provider or provider's staff can effectively communicate (i.e., speak or translate) from the list below: <u>Languages Spoken</u> Spanish Other, identify
Formula	Enter as many non-English languages that are spoken. If one provider's service location can communicate in multiple languages, enter all the languages in one field; if "Other, identify" is selected limit description to 25 alpha/numeric characters.
16. ADA Accessible	
Qualifications/ Definitions	Identify the types of accessibility that the provider's service location offers in compliance with the Americans with Disabilities Act (ADA). <u>ADA Accessibility</u> W-Wheelchair automatic doors E-Elevator (Continued on the next page.)

Qualifications/ Definitions (Continued)	(Continued from the previous page.) R-Ramp A-Assistance to transfer from wheelchair P-Parking B-Bathroom facilities O-Other, identify S-Sign language T-TDY telephonic assistance N-None required
Formula	Enter as many letter codes as appropriate to describe the ADA accessibility (e.g., W, E, R, A, P, B, O, S, T or N). If the provider does not have service locations that provides services directly to members in person, select 'None required'. If "Other, identify" is selected, limit description to 25 alpha/numeric characters.

Table AN-N2: County Listing

County Codes					
0	All Indiana counties				
1	Adams	32	Hendricks	63	Pike
2	Allen	33	Henry	64	Porter
3	Bartholomew	34	Howard	65	Posey
4	Benton	35	Huntington	66	Pulaski
5	Blackford	36	Jackson	67	Putnam
6	Boone	37	Jasper	68	Randolph
7	Brown	38	Jay	69	Ripley
8	Carroll	39	Jefferson	70	Rush
9	Cass	40	Jennings	71	St. Joseph
10	Clark	41	Johnson	72	Scott
11	Clay	42	Knox	73	Shelby
12	Clinton	43	Kosciusko	74	Spencer
13	Crawford	44	LeGrange	75	Starke
14	Daviess	45	Lake	76	Steuben
15	Dearborn	46	LaPorte	77	Sullivan
16	Decatur	47	Lawrence	78	Switzerland
17	DeKalb	48	Madison	79	Tippecanoe
18	Delaware	49	Monroe	80	Tipton
19	Dubois	50	Marshall	81	Union
20	Elkhart	51	Martin	82	Vanderburgh
21	Fayette	52	Miami	83	Vermillion
22	Floyd	53	Monroe	84	Vigo
23	Fountain	54	Montgomery	85	Wabash
24	Franklin	55	Morgan	86	Warren
25	Fulton	56	Newton	87	Warrick
26	Gibson	57	Noble	88	Washington
27	Grant	58	Ohio	89	Wayne
28	Greene	59	Orange	90	Wells
29	Hamilton	60	Owen	91	White
30	Hancock	61	Parke	92	Whitley
31	Harrison	62	Perry	93	Other, identify


Insert MCO name.
MCO Name
Reporting Period_____
Enter the reporting period to which the data applies.
Insert the provider's service location(s) by street address and suite number. If the provider listed has five or less service locations, enter the provider name with each service location on separate lines. If the provider has more than five service locations, enter one primary service location and multiple county codes, if appropriate.
Indicate the type(s) of ADA accessibility for the listed provider service location from the code description menu; if "Other, identify" limit description to 25 alpha/numeric characters.
Item No.
Provider Identification
Type
ID Number
Provider Name
Last Name
First Name
Middle Initial
Service Location(s)
Street Address and Suite Number
City
County Code(s)
State
Zip Code
Telephone Number(s)
Area Code
Phone Number
Languages Spoken
ADA Accessible
Enter a consecutive number for each provider or provider office location beginning with the number 1.
Insert the provider's Medicaid identification number.
Select the provider type from the menu list in the code descriptions; if "Other, identify", limit description to 25 alpha/numeric characters.
Insert the last name of the provider. If a facility or ancillary provider, insert complete name of company or organization, e.g., St. Francis Hospital, or ABC Pharmacy.
Insert the first name of the provider. If the provider is a facility or ancillary provider, leave this field blank.
Insert the provider's middle name initial. If the provider is a facility or ancillary provider, leave this field blank.
Insert city names in which the provider has service locations.
Insert the name of the county(ies) from the code descriptions menu list that the provider services from the identified location; if "Other, identify", include county name and two-letter state identification and limit description to 25 alpha/numeric characters.
Indicate the two letter state abbreviation in which the provider's service locations exist.
Insert the area code for the provider's service location(s) telephone number(s).
Insert the provider's service location(s) telephone number(s).
Indicate the non-English languages spoken by the provider or provider service location staff from the code descriptions menu; if "Other, identify" limit description to 25 alpha/numeric characters.

Provider Types

Chiropractor
Clinics/Health Department (not FQHC/RHC)
Durable Medical Equipment
FQHC/RHC
Home Health
Hospital
Laboratory
Optometrist
Other, identify
Pharmacy
PMP General Practice
PMP Family Practice
PMP General Pediatrics
PMP General Internal Medicine
PMP Obstetrics/Gynecology
Podiatrist
Specialist Physician, identify
Therapist, identify

Languages Spoken

Spanish
Other, identify

ADA Accessibility

W-Wheelchair automatic doors
E-Elevator
R-Ramp
A-Assistance to transfer from wheelchair
P-Parking
B-Bathroom facilities
O-Other, identify
S-Sign language
T-TDY telephonic assistance
N-None required

County Codes

0	All Indiana counties				
1	Adams	32	Hendricks	63	Pike
2	Allen	33	Henry	64	Porter
3	Bartholomew	34	Howard	65	Posey
4	Benton	35	Huntington	66	Pulaski
5	Blackford	36	Jackson	67	Putnam
6	Boone	37	Jasper	68	Randolph
7	Brown	38	Jay	69	Ripley
8	Carroll	39	Jefferson	70	Rush
9	Cass	40	Jennings	71	St. Joseph
10	Clark	41	Johnson	72	Scott
11	Clay	42	Knox	73	Shelby
12	Clinton	43	Kosciusko	74	Spencer
13	Crawford	44	LeGrange	75	Starke
14	Daviess	45	Lake	76	Steuben
15	Dearborn	46	LaPorte	77	Sullivan
16	Decatur	47	Lawrence	78	Switzerland
17	DeKalb	48	Madison	79	Tippecanoe
18	Delaware	49	Monroe	80	Tipton
19	Dubois	50	Marshall	81	Union
20	Elkhart	51	Martin	82	Vanderburgh
21	Fayette	52	Miami	83	Vermillion
22	Floyd	53	Monroe	84	Vigo
23	Fountain	54	Montgomery	85	Wabash
24	Franklin	55	Morgan	86	Warren
25	Fulton	56	Newton	87	Warrick
26	Gibson	57	Noble	88	Washington
27	Grant	58	Ohio	89	Wayne
28	Greene	59	Orange	90	Wells
29	Hamilton	60	Owen	91	White
30	Hancock	61	Parke	92	Whitley
31	Harrison	62	Perry	93	Other, identify

General Report Description	
AN-N3 Subcontractor Compliance Summary	
Purpose	Identify the MCO's subcontractors and document the MCO's oversight of delegated activities.
Required Submission Type	Excel template.
Comments/ Recommendations	This is an ongoing annual report. The MCO must provide the requested information throughout the year to OMPP during on-site monitoring visits. The Excel template is provided for the MCO's convenience. OMPP does not require the MCO to use the Excel template, but the MCO must be able to provide the information described below. For the purposes of this report, a subcontractor is defined as an entity that manages and administers health care service delivery functions not solely related to direct patient care. PMPs' and specialty physicians' contracts do not need to be included in this report.
Performance Measures	The MCO must notify OMPP and request OMPP's approval 60 calendar days prior to the use or change of any subcontractor or subcontractor's agreement.
AN-N3 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the calendar year for which subcontractor information is being submitted.
Formula	Enter the calendar year for which the data applies.
2. Item No.	
Qualifications/ Definitions	Consecutively number subcontractors listed on the report.
Formula	Indicate a consecutive number for each subcontractor listed beginning with number 1.
3. MBE/WBE	
Qualifications/ Definitions	Identify the subcontractors listed that meet the minority or women business enterprise (MBE/WBE) definitions.
Formula	Enter "X" in the field if applicable.

4. Subcontractor Name	
Qualifications/ Definitions	Identify the MCO's subcontractors that deliver the contracted services. OMPP requires all subcontractors to be identified in annual reports until after the MCO reports a termination date for the subcontractor's services.
Formula	Insert the name of the MCO's subcontractor as listed on its contract with the MCO.
5. Delegated Activities	
Qualifications/ Definitions	Identify the type of activities the subcontractor performs or the services it offers supporting the MCO's contract with the State using the descriptions below: <u>Delegated Activities</u> Accounts Receivable/Accounts Payable Claims Processing/Data Systems Disease Management Network Development Non-emergent Transportation Member Services Other, identify Pharmacy Benefit Management Prior Authorization/Medical Management Provider Credentialing Provider Services Website Development/Management
Formula	Insert the delegated activities description from the options; if "Other, identify", limit to 25 alpha/numeric characters.
6. OMPP Approval Date	
Qualifications/ Definitions	Identify the date OMPP approved the subcontractor agreement.
Formula	Enter date in MM/DD/YY format.

7. Contract Start Date	
Qualifications/ Definitions	Identify the effective date of the subcontractor's contract with the MCO (i.e., the date the subcontractor will begin delivering the contracted services).
Formula	Enter date in MM/DD/YY format.
8. Contract End Date	
Qualifications/ Definitions	Identify the end date of the subcontractor's current contracted term. End dates cannot extend beyond the termination date of the MCO's contract with the State.
Formula	Enter date in MM/DD/YY format.
9. Contract Type	
Qualifications/ Definitions	Identify the type of financial arrangement under which the subcontractor will deliver services by using the following descriptions: Non-risk, meaning the subcontractor has no risk or risk is less than five percent of the MCO's revenue from the Hoosier Healthwise contract. Risk, meaning the subcontractor has risk equaling five percent or more of the MCO's revenue from Hoosier Healthwise contract.
Formula	Select the contract type from the options.
10. Financial Information Obtained	
Qualifications/ Definitions	Confirm that the MCO has collected the required quarterly financial information when the subcontractor's financial arrangement is "Risk" by indicating the following options: Yes, meaning the MCO has collected the required financial information each quarter of the prior calendar year. No, meaning the MCO has not collected required financial information each quarter of the prior calendar year.
Formula	Select the indicator from the options.

11. Stop Loss Coverage	
Qualifications/ Definitions	Identify subcontractor's stop loss insurance coverage arrangement using the following indicators: <u>Stop Loss Description</u> Yes, this subcontractor has its own stop loss coverage No, this subcontractor does not have its own stop loss coverage Stop loss is not applicable to this subcontractor, explain
Formula	Select the stop loss indicator from the menu; if stop loss is not applicable, explain why stop loss does not apply in 200 alpha/numeric characters.
12. MCO Committee Participation	
Qualifications/ Definitions	Identify the subcontractor's participation in the MCO's internal committee structure using the following descriptions: <u>Committee Participation:</u> Participates 50 percent or more [in any one or more committee(s)] Participates less than 50 percent [in any one or more committee(s)] Does not participate [in any internal MCO committee(s)]
Formula	Select committee participation description from the options.
13. Committee Name(s)	
Qualifications/ Definitions	If participating in MCO committee(s), indicate the name(s) of committee(s) in which subcontractor(s) participates; if participating in more than one committee, list each committee separately.
Formula	Enter committee name(s) separately; limit committee name to 50 alpha/ numeric characters.
14. Monitoring Activities	
Qualifications/ Definitions	Identify the monitoring activities the MCO employs to oversee the subcontractor's compliance with the terms of the MCO's contract with the State.
Formula	Limit monitoring activities descriptions to 200 alpha/numeric characters per activity.

15. Corrective Action Start Date	
Qualifications/ Definitions	Indicate the date any formal or informal corrective actions were implemented as a result of the MCO monitoring activities. If there were no corrective actions as a result of monitoring activities, leave this field blank.
Formula	Enter date(s) for each corrective action taken during the reporting period in MM/DD/YY format.
16. Corrective Action End Date	
Qualifications/ Definitions	Indicate the date that the MCO confirmed the subcontractor's activities were again in compliance. If there were no corrective actions as a result of monitoring activities, leave this field blank.
Formula	Enter date(s) for each corrective action taken during the reporting period in MM/DD/YY format.
17. Corrective Action Outcome	
Qualifications/ Definitions	Briefly describe the outcomes of any corrective actions that the MCO and subcontractor instituted subsequent to the MCO's monitoring process.
Formula	Limit descriptions to 200 alpha/numeric characters per corrective action.

MCO Name: _____

Reporting Period_____

Insert MCO name.

Enter the calendar year for which the data applies.

Describe the type(s) of monitoring activities that the MCO completed to ensure the subcontractor's delivery of delegated activities was compliant to the MCO's contract with the State; limit to 200 alpha/numeric characters.

Item No.	MBE/ WBE	Sub-contractor Name	Delegated Activities	OMPP Approval Date	Contract Start Date	Contract End Date	Contract Type	Financial Information Obtained	Stop Loss Coverage	Committee Participation	Committee Name(s)	Monitoring Activities	Corrective Actions Start Date	Corrective Actions End Date	Corrective Action Outcomes
Consecutively number each subcontractor listed beginning with number 1.	Place an X in this column when the subcontrator meets the MBE/WBE definition.	Indicate the name of the subcontractor as written on its contract with the MCO.	Insert the delegated activities from the options.	Indicate the date in MM/DD/YY format that OMPP approved the subcontractor agreement.	Indicate the date in MM/DD/YY that the subcontractor's contract becomes effective.	Indicate the date in MM/DD/YY format that the MCO's contract with the subcontractor will end or has ended.	Select the contract type from the options.	If "Risk" selected in "Contract Type", select indicator from the menu confirming the MCO has/has not collected the required quarterly financial information.	Select stop loss coverage description from the options.	Select committee participation description from the options.	If subcontractor participates in MCO's committee(s), list the name(s) of the committee(s) in no more than 50 alpha/numeric characters for each committee.	Indicate the date(s) the MCO implemented a corrective action in MM/DD/YY format.	Indicate the date(s) the MCO confirmed the subcontractor was again in compliance; enter date in MM/DD/YY format.	Describe the outcomes in no more than 200 alpha/numeric characters per action.	

Delegated Activities Descriptions
Accounts Receivable/Accounts Payable
Claims Processing/Data Systems
Disease Management
Network Development
Non-emergent Transportation
Member Services
Other, identify
Pharmacy Benefit Management
Prior Authorization/Medical Management
Provider Credentialing
Provider Services
Website Development/Management

Committee Participation
Participates 50 percent or more
Participates less than 50 percent
Does not participate

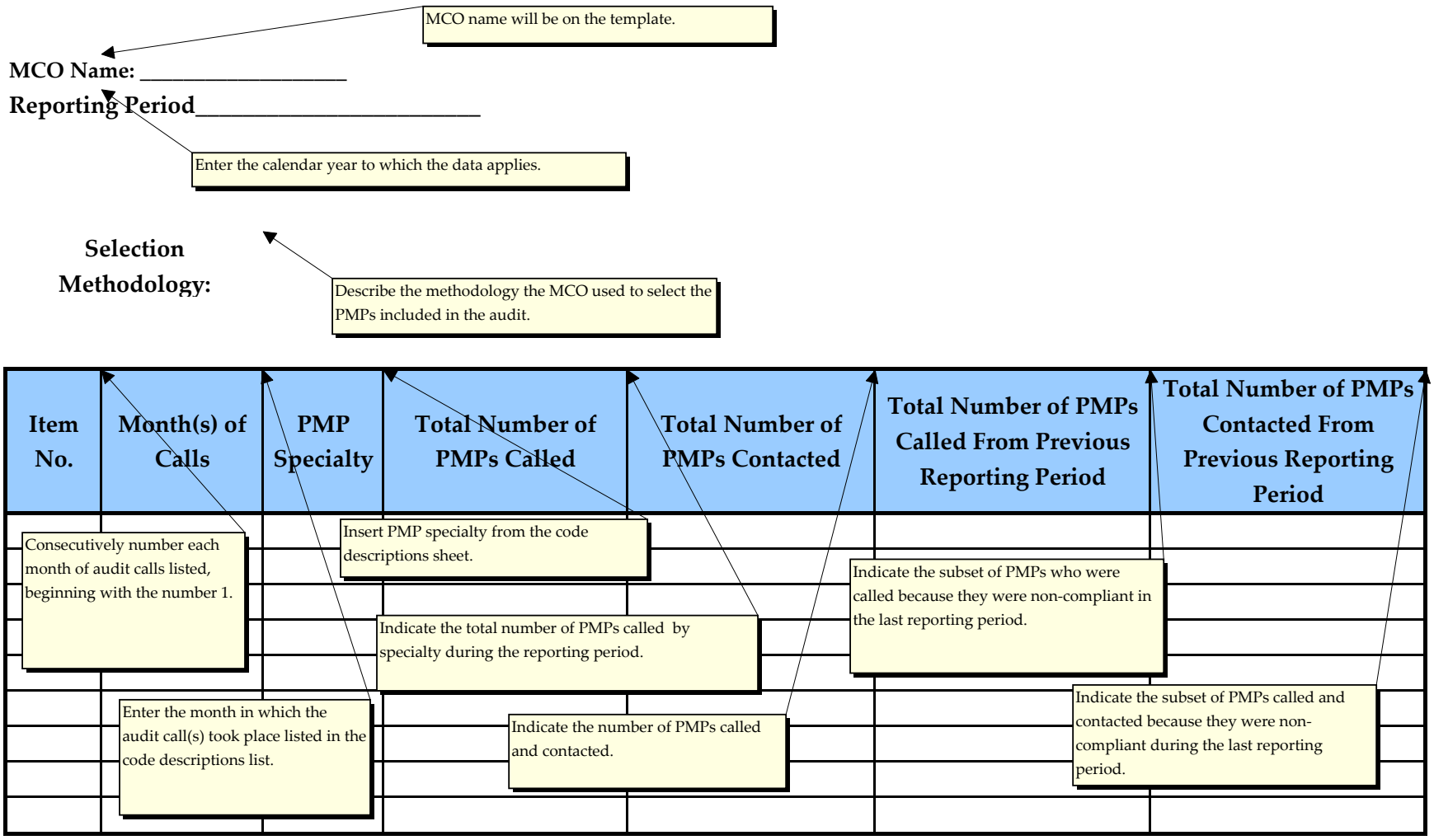
Stop Loss Description
Yes, this subcontractor has its own stop loss coverage
No, this subcontractor does not have its own stop loss coverage
Stop loss is not applicable to this subcontractor, explain

Contract Types
Non-risk
Risk

General Report Description	
AN-N4 24-Hour Availability Audit	
Purpose	Monitor member's access to PMPs after regular business hours.
Required Submission Type	Excel template
Comments/ Recommendations	This is an annual report. The MCO must submit this report to the monitoring contractor and OMPP by January 31st of each year. Members should be able to access PMPs 24-hours-a-day, seven-days-a-week, for urgent/emergent health care needs. Therefore, PMPs must have a mechanism in place to ensure that members are able to make direct contact with their PMP, or the PMP's clinical staff person, through a toll-free member services telephone number 24-hours-a-day, seven-days-a-week. To monitor that members have appropriate 24-hours-a-day, seven-days-a-week access to PMPs, the MCO must randomly select PMPs to receive test calls each year. The sample size must be a minimum of five percent of the MCO's PMP network to include an even representation of each mandatory risk-based managed care (RBMC) county and each PMP specialty throughout the MCO's network. PMPs are deemed available to provide services if they answer the phone themselves, designate an employee, hire an answering service, or a use a pager system to facilitate members' contact with an on-call medical professional 24-hours-a-day, seven-days-a-week. MCOs must notify PMPs who are found non-compliant with the 24-hour availability requirement and must put corrective actions in place with the PMP within 30 days of notification. The MCO must monitor the non-compliant PMPs in the following year to determine availability. The MCO must complete these PMP calls in addition to the annual monitoring sample. The MCO must identify in its Quality Management and Improvement Summary (AN-Q2) the steps taken to communicate audit results to PMPs and the steps the MCO has taken to achieve future compliance.
Performance Measures	MCO should have 100 percent compliance. OMPP will calculate compliance rate(s) using annual data.

AN-N4 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the calendar year in which the availability audit(s) were conducted.
Formula	Select the calendar year from the menu.
2. Selected Methodology	
Qualifications/ Definitions	Describe the methodology used to identify and select the PMPs to be included in the audit.
Formula	Enter narrative text; limit description to 200 alpha/numeric characters.
3. Item No.	
Qualifications/ Definitions	Consecutively number all PMP calls by the PMP's service location county listed on the report.
Formula	Consecutively number each call beginning with number 1.
4. Month(s) of Calls	
Qualifications/ Definitions	Identify the number of audit calls by the PMP's service location county and by the month in which the call occurred. Multiple months can be identified for each service location county.
Formula	Select the months from the menu.
5. PMP Specialty	
Qualifications/ Definitions	Identify the PMP specialty by number of calls made during the month the audit(s) was conducted using the following specialty descriptions: <u>PMP Specialties</u> General practice Family practice General pediatrics General internal medicine Obstetrics/Gynecology OMPP may request the identification of the individual providers that the MCO called or called and contacted.
Formula	Enter the PMP specialty description from the menu.

6. Total Number of PMPs Called	
Qualifications/ Definitions	Indicate the number of audit calls initiated during the month. This number should include all PMPs by specialty who were newly selected for calling in this reporting period as well as those PMPs who were found non-compliant in the previous reporting period.
Formula	Enter number of PMPs called by PMP specialty.
7. Total Number of PMPs Contacted	
Qualifications/ Definitions	Identify the number of PMPs called and successfully contacted by specialty to monitor 24-hour availability. This number is a subset of "Total Number of PMPs Called." However, if all PMPs that were called were also contacted, this number will equal "The Number of PMPs Called."
Formula	Enter number of PMPs contacted by PMP specialty.
8. Total Number of PMPs Called From Previous Reporting Period	
Qualifications/ Definitions	Identify the number of PMPs by specialty who were called because they were deemed non-compliant during the previous reporting period. This number is a subset of the "Total Number of PMPs Called."
Formula	Enter number of PMPs called by PMP specialty.
9. Total Number of PMPs Contacted From Previous Reporting Period	
Qualifications/ Definitions	Identify the number of PMPs by specialty who were deemed non-compliant during the previous reporting period and were called and successfully contacted during the current audit for this reporting period. This number is a subset of the "Total Number of PMPs Contacted" and a subset of "Total Number of PMPs Called from Previous Period." However, if all PMPs from previous reporting period that were called were also contacted, this number will equal "Total Number of PMPs Called from Previous Period."
Formula	Enter number of PMPs contacted by PMP specialty.

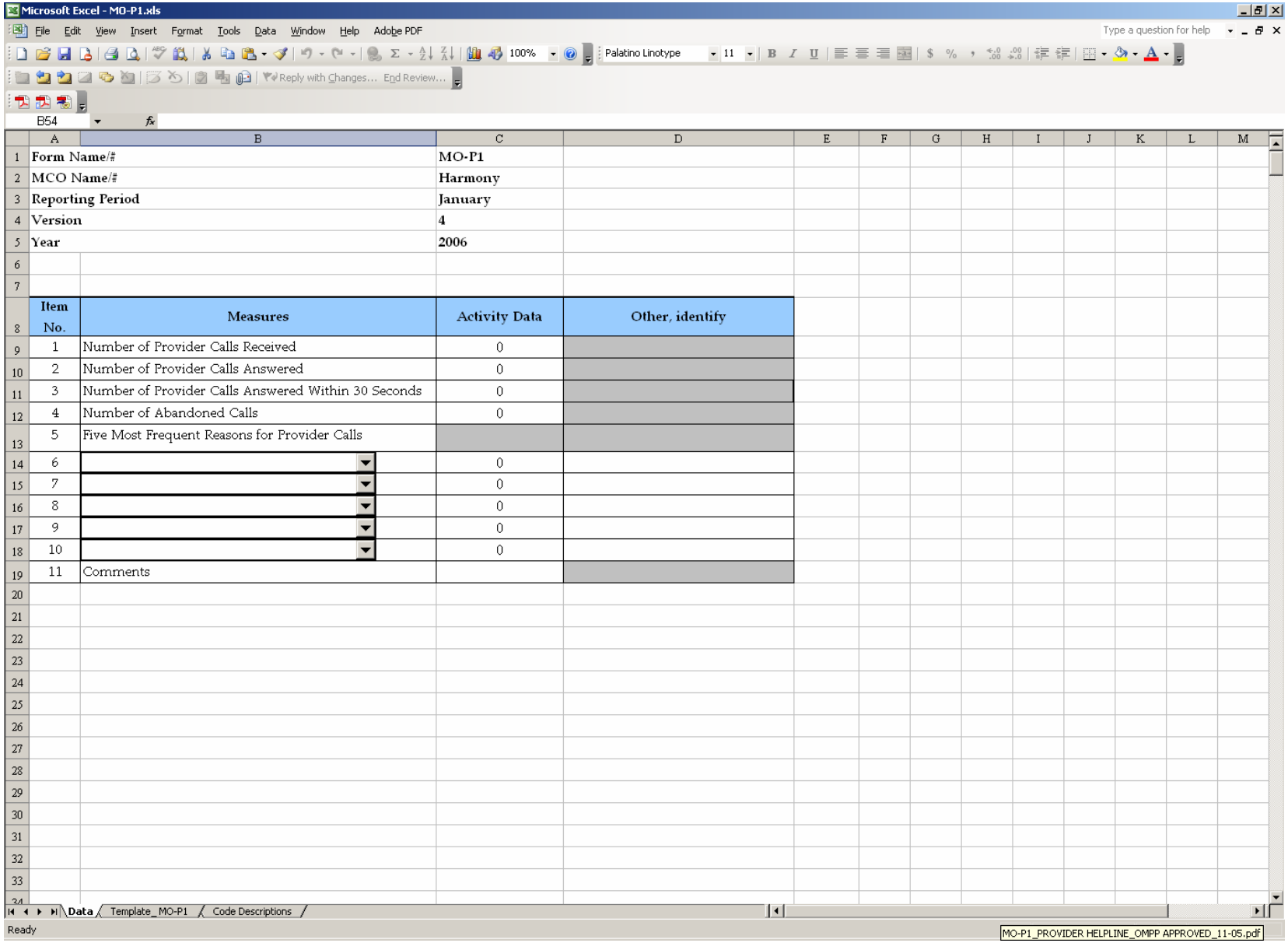

MCO name will be on the template.
MCO Name: _____
Reporting Period_____
Enter the calendar year to which the data applies.
Selection Methodology:
Describe the methodology the MCO used to select the PMPs included in the audit.
Item No.
Month(s) of Calls
PMP Specialty
Total Number of PMPs Called
Total Number of PMPs Contacted
Total Number of PMPs Called From Previous Reporting Period
Total Number of PMPs Contacted From Previous Reporting Period
Consecutively number each month of audit calls listed, beginning with the number 1.
Insert PMP specialty from the code descriptions sheet.
Indicate the subset of PMPs who were called because they were non-compliant in the last reporting period.
Indicate the total number of PMPs called by specialty during the reporting period.
Enter the month in which the audit call(s) took place listed in the code descriptions list.
Indicate the number of PMPs called and contacted.
Indicate the subset of PMPs called and contacted because they were non-compliant during the last reporting period.

Months	PMP Specialties
January	General practice
February	Family practice
March	General pediatrics
April	General internal medicine
May	Obstetrics/Gynecology
June	
July	
August	
September	
October	
November	
December	

General Report Description	
MO-P1 Provider Helpline Performance	
Purpose	Monitor MCO's availability to provide service to its providers calling the MCO's Provider Helpline.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a monthly report. The MCO must submit the report to the monitoring contractor and OMPP by the 15th day of the month following the end of the reporting period. At OMPP's discretion, the MCO may submit monthly data on a quarterly basis by the last day of the month following the end of the reporting quarter. OMPP is providing one template for each month of the year. The MCO must submit its data using the appropriately named template. For example, MO-P1_Apr_06.xls is the template name for April's data.
Performance Measures	The MCO must maintain its average monthly telephone service for provider services helpline with service efficiency at 85 percent of calls received being answered by a live voice within 30 seconds (i.e., an 85 percent service efficiency rate) and less than five percent of the calls received in the Provider Helpline remaining unanswered.
MO-P1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Select the calendar year and reporting month or quarter for which the Provider Helpline data is being submitted.
Formula	This field will auto populate to identify the reporting period.
2. Number of Provider Calls Received	
Qualifications/ Definitions	Identify the total number of provider calls received by the MCO Provider Helpline during open hours of operation, including calls in which the provider calls directly into the Provider Helpline, transfers into the Provider Helpline or selects a provider services option placing the provider into the call queue. This does not apply to other external call centers (e.g., pharmacy).
Formula	Total number of calls received in the Provider Helpline ACD call queue. OMPP will calculate year-to-date activity from monthly data.

3. Number of Provider Calls Answered	
Qualifications/ Definitions	Identify the number of provider calls answered on the Provider Helpline in each month of the reporting month. This number should not be greater than the number of calls received and should include the number of calls answered within 30 seconds by a live voice.
Formula	Total number of calls received and answered that enter the Provider Helpline ACD call queue. OMPP will calculate year-to-date activity from monthly data.
4. Number of Provider Calls Answered Live Within 30 Seconds	
Qualifications/ Definitions	Identify the number of provider calls answered within 30 seconds by a live voice on the Provider Helpline in each reporting month. This number should not be greater than the number of calls received.
Formula	Total number of calls received and answered within 30 seconds by a live voice entering the Provider Helpline ACD call queue. OMPP will calculate year-to-date activity from monthly data.
5. Number of Abandoned Calls	
Qualifications/ Definitions	Identify the number of calls received into the MCO's Provider Helpline during open hours of operation that were abandoned (disconnected) by the caller or the system before being answered.
Formula	Enter number of calls abandoned. OMPP will calculate MCO's abandonment rate using the number of calls received during open hours of operations but not answered before disconnecting divided by total number of calls received, multiplied by 100.
6. Five Most Frequent Reasons for Provider Calls	
Qualifications/ Definitions	Identify the five most frequent reasons for providers calling the Provider Helpline by the reasons below. The reasons for the calls should be tabulated from all calls answered and listed from the reason with the highest to the lowest number of calls. <u>Frequent Reasons</u> General Plan Information General Provider Information Inquiry Regarding Dispute Procedures (Continued on the next page.)

6. Five Most Frequent Reasons for Provider Calls (Continued)	
Qualifications/ Definitions (Continued)	(Continued from the previous page.) Other, Identify Request Covered Benefits Information Request Claims Status Request Authorization Status Request Claim Adjustment/Billing Issue Request Referral Information Request Member Eligibility Information
Formula	Enter a reason from the menu, entering the reasons consecutively with the most frequent reason first; if "Other, identify", enter a text reason limited to 50 alpha/numeric characters. OMPP will calculate year-to-date activity by reason using monthly data.
7. Total Number of Calls for Top Five Reasons	
Qualifications/ Definitions	Identify the total number of provider calls received for each of the top five reasons. The sum of the number of calls by reason should not be greater than the number of total calls answered.
Formula	Enter number of calls. OMPP will calculate year-to-date activity from monthly data.
8. Comments	
Qualifications/ Definitions	Enter additional details regarding the performance and outcomes of the Provider Helpline as the MCO deems necessary.
Formula	Limit to 100 alpha/numeric characters.



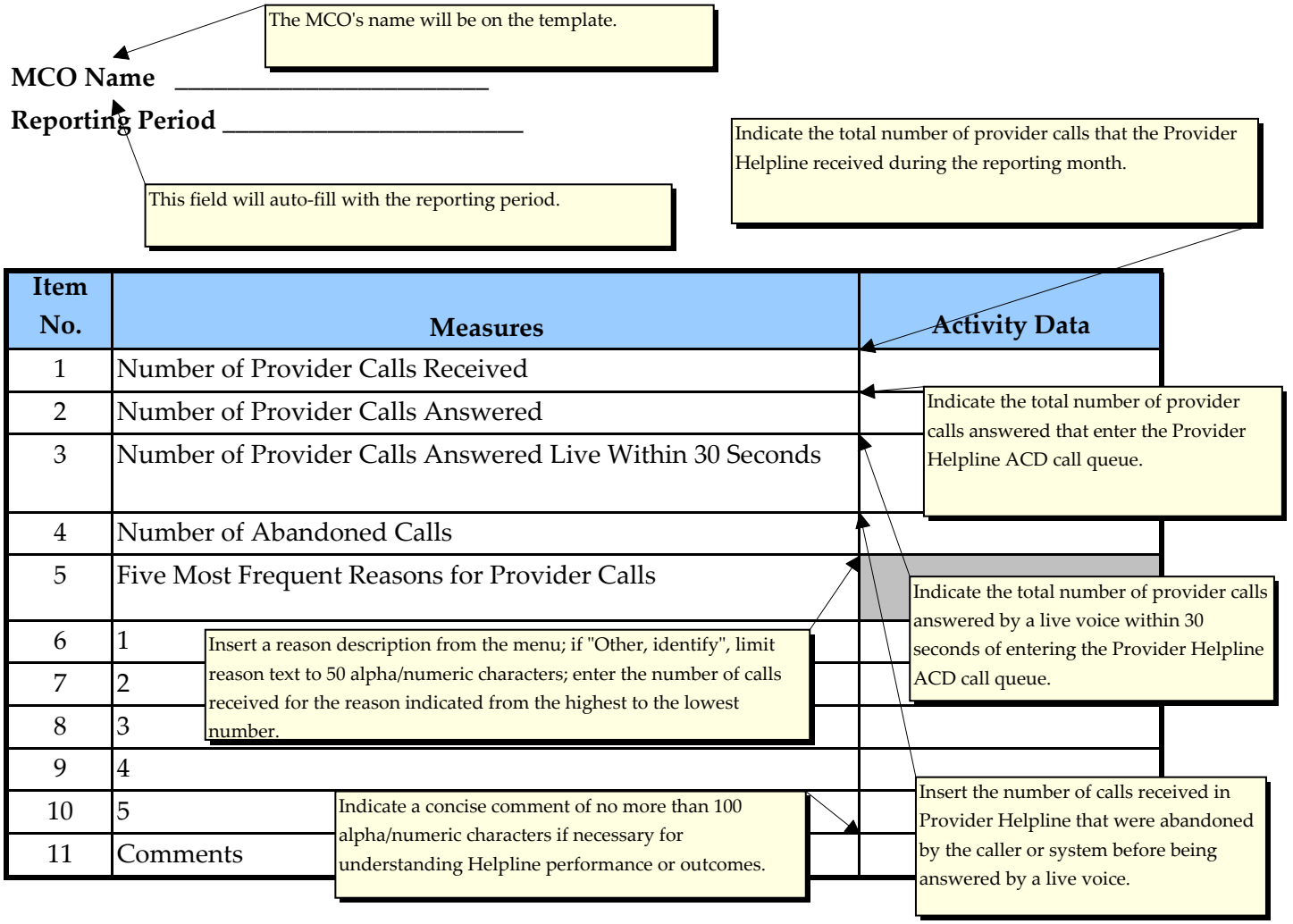
Microsoft Excel - MO-P1.xls

	A	B	C	D
1	Form Name/#		MO-P1	
2	MCO Name/#		Harmony	
3	Reporting Period		January	
4	Version		4	
5	Year		2006	
6				
7				
8	Item No.	Measures	Activity Data	Other, identify
9	1	Number of Provider Calls Received	0	
10	2	Number of Provider Calls Answered	0	
11	3	Number of Provider Calls Answered Within 30 Seconds	0	
12	4	Number of Abandoned Calls	0	
13	5	Five Most Frequent Reasons for Provider Calls		
14	6		0	
15	7		0	
16	8		0	
17	9		0	
18	10		0	
19	11	Comments		

Data | Template_ MO-P1 | Code Descriptions

Ready

MO-P1_PROVIDER HELPLINE_OMPP APPROVED_11-05.pdf


The MCO's name will be on the template.
MCO Name _____
Reporting Period _____
This field will auto-fill with the reporting period.
Indicate the total number of provider calls that the Provider Helpline received during the reporting month.
Item No.
Measures
Activity Data
1 Number of Provider Calls Received
2 Number of Provider Calls Answered
3 Number of Provider Calls Answered Live Within 30 Seconds
4 Number of Abandoned Calls
5 Five Most Frequent Reasons for Provider Calls
6 1
7 2
8 3
9 4
10 5
11 Comments
Indicate the total number of provider calls answered that enter the Provider Helpline ACD call queue.
Indicate the total number of provider calls answered by a live voice within 30 seconds of entering the Provider Helpline ACD call queue.
Insert a reason description from the menu; if "Other, identify", limit reason text to 50 alpha/numeric characters; enter the number of calls received for the reason indicated from the highest to the lowest number.
Indicate a concise comment of no more than 100 alpha/numeric characters if necessary for understanding Helpline performance or outcomes.
Insert the number of calls received in Provider Helpline that were abandoned by the caller or system before being answered by a live voice.

Frequent Reasons for Provider Calls

General Plan Information
General Provider Information
Inquiry Regarding Dispute Procedures
Other, identify
Request Covered Benefits Information
Request Claims Status
Request Authorization Status
Request Claim Adjustment/Billing Issue
Request Referral Information
Request Member Eligibility Information

General Report Description	
QR-P1 Informal Provider Claims Disputes	
Purpose	Monitor the volume of MCO informal provider claims disputes received from out-of-network providers quarterly by month.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report. The MCO must submit this report to the monitoring contractor and OMPP by the last day of the month following the end of the calendar quarter. This report must be submitted by the MCO for those provider disputes received from providers who do not have an agreement in place (i.e., out-of-network) with the MCO that describes a provider dispute process. The MCO must refer to Table QR-P1: Informal Claims Dispute Resolution Matrix (attached) for more information on the claims dispute policy.
Performance Measures	MCO must determine a resolution within 30 calendar days of receiving the provider's dispute.
QR-P1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting quarter informal claims disputes data is being submitted.
Formula	Select reporting period from menu.
2. Total Number of Informal Disputes Received	
Qualifications/ Definitions	Identify the number of all verbal or written informal disputes received by month during the reporting quarter as of the last day of each month.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.

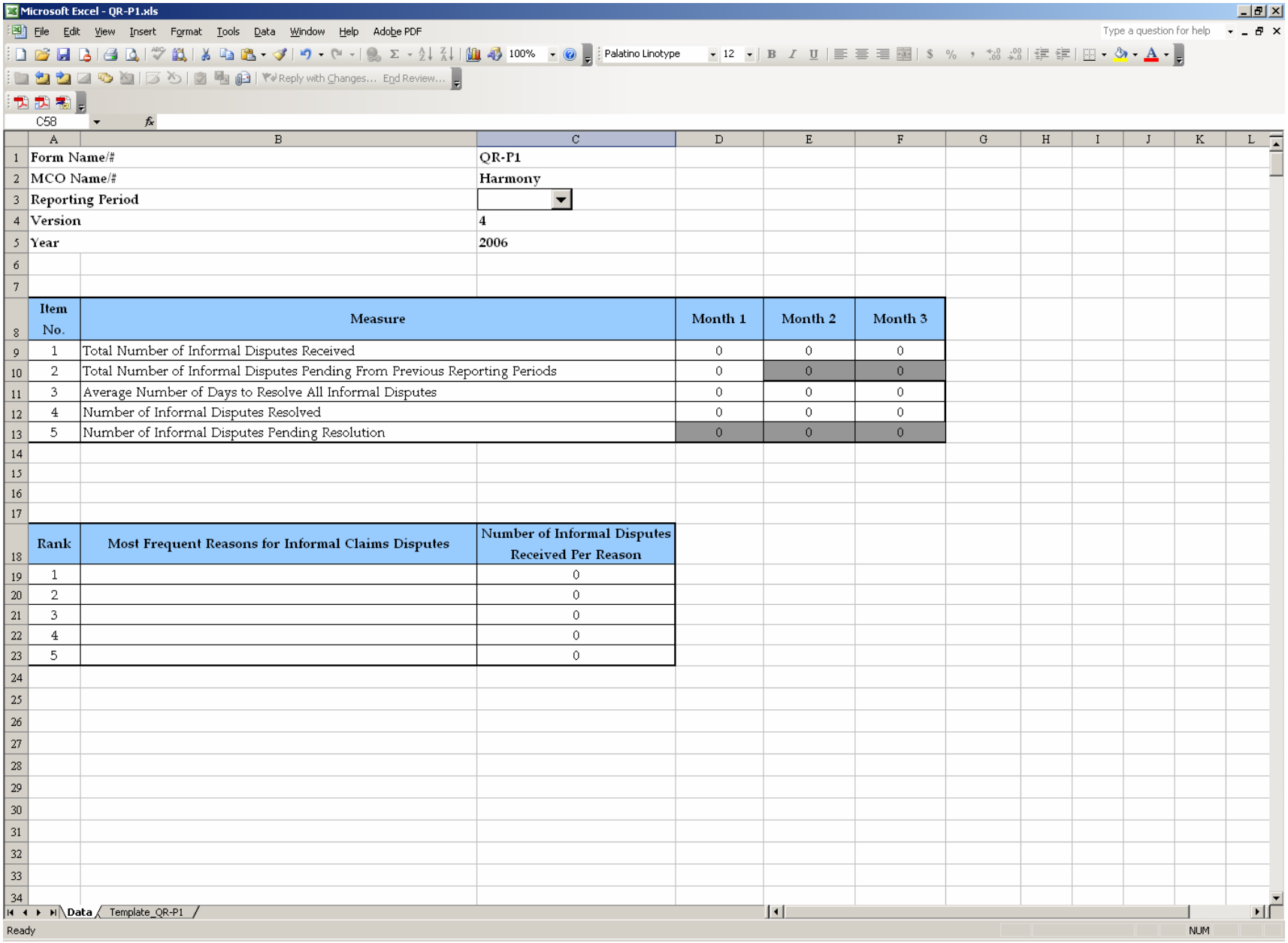
3. Total Number of Informal Disputes Pending From Previous Reporting Periods	
Qualifications/ Definitions	Identify the number of verbal or written informal provider disputes that were received in previous months and not resolved as of the last day of the last month.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.
4. Average Number of Days to Resolve All Informal Disputes	
Qualifications/ Definitions	Calculate resolution times in calendar days from the date the MCO received the verbal or written informal provider dispute to the day the MCO notified the provider of a resolution determination.
Formula	Julian day of the date of the decision of the informal provider claims dispute (-) Julian day of the date the MCO received the informal provider claims dispute = The number of days. Total number of calendar days to resolve all informal provider claims disputes resolved in the month ÷ Total number of all informal provider claims disputes resolved in the month = The average number of calendar days to resolve informal provider claims disputes in the month. OMPP will calculate quarterly and year-to-date activity using monthly data.
5. Number of Informal Disputes Resolved	
Qualifications/ Definitions	Enter the total number of informal provider claims disputes resolved by month during the reporting period. OMPP considers a provider claims dispute to be resolved when the provider has been notified of the resolution decision. Until notification, OMPP considers the resolution to be pending.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.
6. Number of Informal Disputes Pending Resolution	
Qualifications/ Definitions	Insert the total number of informal provider claims disputes pending resolution as of the last day of the month. In subsequent months, this number should be reported until a resolution is determined under Item 3 (above): "Total Number of Informal Disputes Pending From Previous Reporting Periods."
Formula	This number will auto-fill. OMPP will calculate quarterly and year-to-date activity using monthly data.

7. Rank	
Qualifications/ Definitions	Identify the five most frequent reasons for informal provider claims disputes for the reporting quarter.
Formula	Rate the most frequent reason as number 1 and the fifth most frequent reason as number 5 for the informal provider claims disputes received during the reporting period.
8. Most Frequent Reasons for Informal Claims Disputes	
Qualifications/ Definitions	Identify the reason for the informal provider claims disputes received most frequently stated during the reporting quarter.
Formula	Enter a brief text description for each of the five most frequent reasons for informal provider claims disputes; limit 100 alpha/numeric characters.
9. Number of Informal Disputes Received	
Qualifications/ Definitions	Identify the total number of informal provider claims disputes received during the reporting quarter by the indicated dispute reason.
Formula	Enter total numbers. OMPP will calculate the percent of disputes received by reason using the number of informal provider claims disputes received for each reason divided by the total number of all informal provider claims disputes received during the quarter, multiplied by 100.

TABLE QR-P1: Informal Claims Dispute Resolution Matrix

Issue	Final Policy
1. Definition of an informal claim dispute resolution review.	• The informal claim resolution procedure must precede the formal claim resolution procedure, and shall be used to informally resolve a provider's objection to a determination (or failure to make a determination) by the MCO involving the provider's claim. • The provider and MCO may make verbal or written inquiries and may informally undertake to resolve the matter initiated and submitted for resolution by the provider.
2. Timeframe for the provider to request an informal claims dispute resolution review.	• A provider will have 60 calendar days from the receipt of a claim determination to file a written objection and request an informal claim dispute resolution review. • In the event that a claim is not acted on within 30 calendar days of submission, a provider will have - 60 calendar days from the last day of MCO's claim determination period to file a written objection and request a formal claim dispute resolution review; or - 90 calendar days of claims submission, if the MCO has not made a determination within 30 calendar days of claim submission.
3. Timeframe for the MCO to acknowledge the receipt of a request for an informal claim dispute resolution review.	• The MCO must acknowledge either verbally or in writing the receipt of a request for an informal claim resolution review within five business days of the receipt of the request for an informal claim review.
4. Informal claim dispute resolution timeframe.	• In the event the matter submitted for informal resolution is not resolved to the provider's satisfaction within 30 calendar days after the provider commences the informal claim resolution procedure, the provider shall have 60 calendar days from that point to submit the matter to the formal claims resolution process.
5. Notice of a resolution to the provider.	• The MCO must notify the provider of the determination of an informal claim resolution within five calendar days of the day a decision was reached.

Issue	Final Policy
6. Reporting requirement.	• The MCO shall maintain a log of informally filed provider objections to claims determinations. The log shall include the provider's name, date of objection, nature of objection and disposition. The MCO shall submit quarterly reports to OMPP regarding the number and type of provider objections.

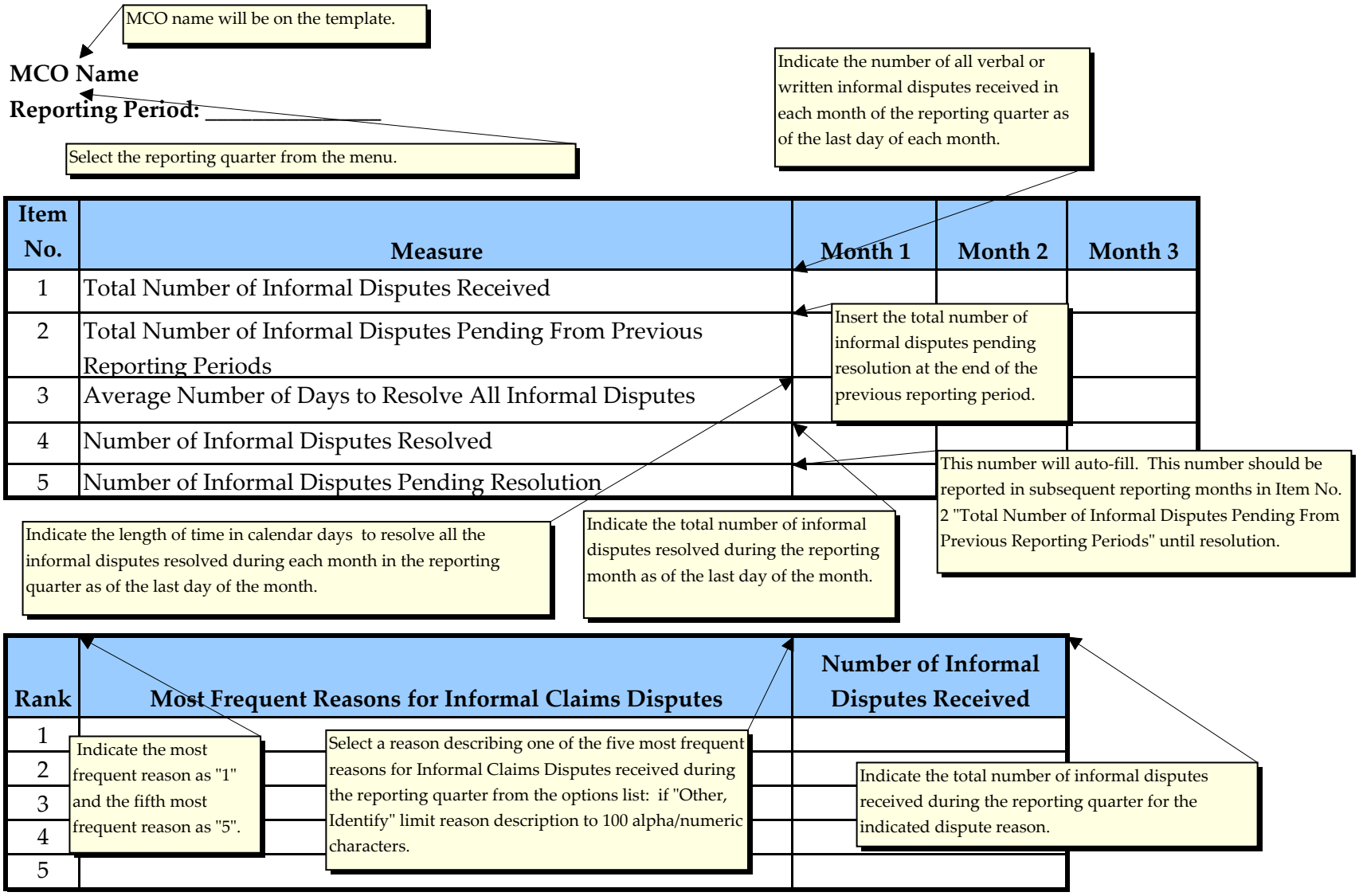


Microsoft Excel - QR-P1.xls

	A	B	C	D	E	F
1	Form Name/#		QR-P1			
2	MCO Name/#		Harmony			
3	Reporting Period					
4	Version		4			
5	Year		2006			

Item No.	Measure	Month 1	Month 2	Month 3
1	Total Number of Informal Disputes Received	0	0	0
2	Total Number of Informal Disputes Pending From Previous Reporting Periods	0	0	0
3	Average Number of Days to Resolve All Informal Disputes	0	0	0
4	Number of Informal Disputes Resolved	0	0	0
5	Number of Informal Disputes Pending Resolution	0	0	0

Rank	Most Frequent Reasons for Informal Claims Disputes	Number of Informal Disputes Received Per Reason
1		0
2		0
3		0
4		0
5		0



Item No.	Measure	Month 1	Month 2	Month 3
1	Total Number of Informal Disputes Received			
2	Total Number of Informal Disputes Pending From Previous Reporting Periods			
3	Average Number of Days to Resolve All Informal Disputes			
4	Number of Informal Disputes Resolved			
5	Number of Informal Disputes Pending Resolution			

Rank	Most Frequent Reasons for Informal Claims Disputes	Number of Informal Disputes Received
1		
2		
3		
4		
5		

General Report Description	
QR-P2 Formal Provider Claims Disputes	
Purpose	Monitor the volume and timely resolution of MCO formal out-of-network provider claims disputes quarterly by month.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report. The MCO must submit this report to the monitoring contractor and OMPP by the last day of the month following the end of the calendar quarter. This report must be submitted by the MCO for those formal provider claims disputes received from providers who do not have an agreement in place (i.e., out-of-network) with the MCO describing a provider dispute process. The MCO must refer to Table QR-P2: Formal Provider Claims Disputes Resolution Matrix (attached) for more information on the claims dispute policy.
Performance Measures	The MCO must render a resolution decision within 45 calendar days from the date it receives the provider's formal claims dispute.
QR-P2 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting quarter for which formal provider claims disputes data is being submitted.
Formula	Select the reporting quarter from the menu.
2. Total Number of Formal Claims Disputes Received	
Qualifications/ Definitions	Indicate the number of all formal provider claims disputes received during the reporting quarter by month as of the last day of the reporting month.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.

3. Total Number of Formal Disputes Pending From Previous Reporting Periods	
Qualifications/ Definitions	Indicate the number of written formal provider claims disputes that were received in previous months and not resolved as of the last day of the previous month.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.
4. Average Number of Days to Resolve All Formal Disputes	
Qualifications/ Definitions	Indicate resolution times in calendar days from the date the MCO received the written formal provider claims dispute to the day the MCO notified the provider of a resolution determination.
Formula	Julian day of the date of the decision of the formal provider claims dispute (-) Julian day of the date the MCO received the formal provider claims dispute = The number of days. Total number of calendar days to resolve all formal provider claims disputes resolved in the month ÷ Total number of all formal provider claims disputes resolved in the month = The average number of calendar days to resolve formal provider claims disputes in the month. OMPP will calculate quarterly and year-to-date activity using monthly data.
5. Number of Formal Disputes Resolved	
Qualifications/ Definitions	Indicate the total number of formal provider claims disputes resolved in each month of the reporting quarter as of the last day of the month. OMPP considers a provider claims dispute to be resolved when the provider has been notified of the resolution decision. Until notification, OMPP considers the resolution to be pending.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.

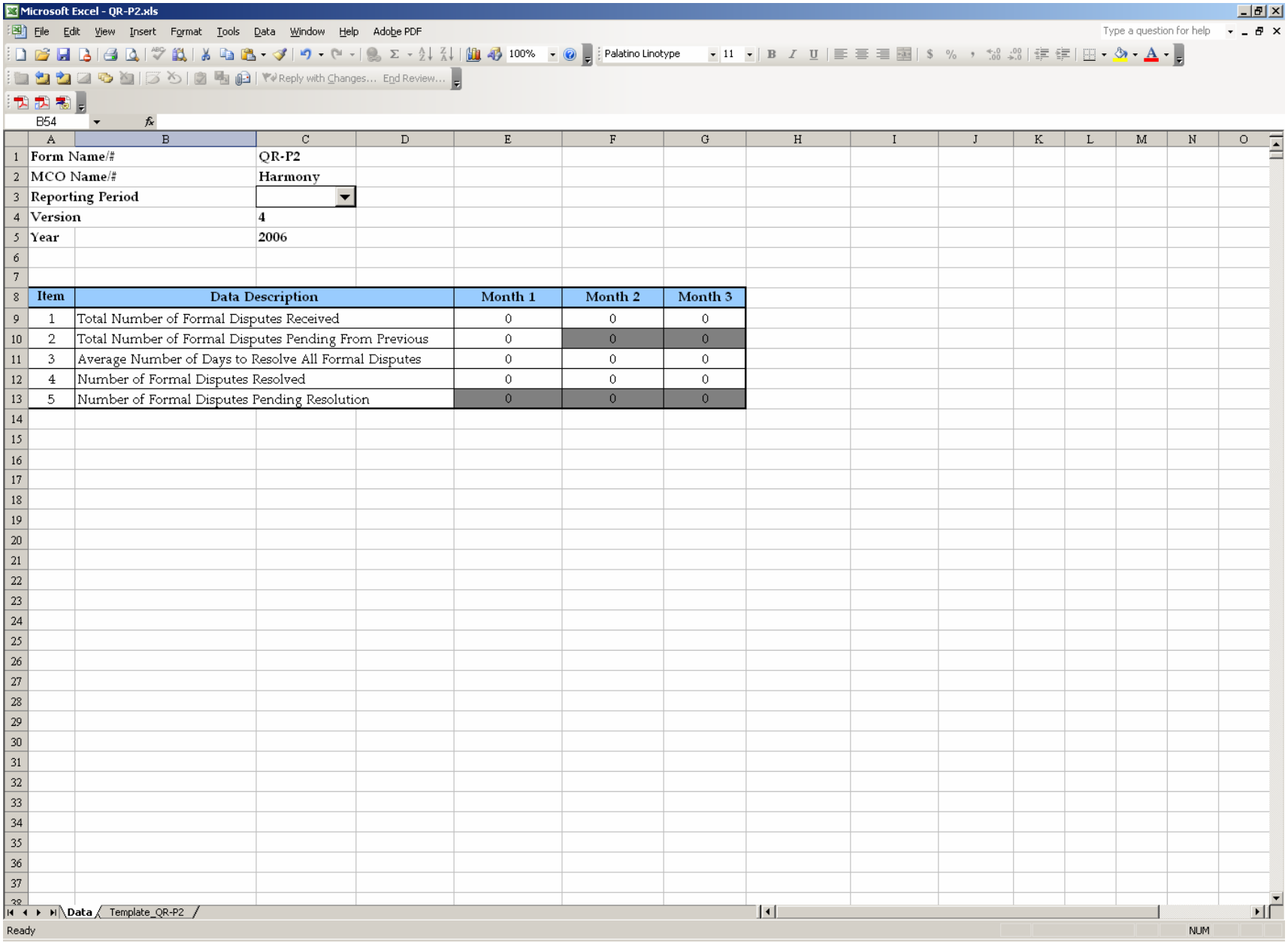
6. Number of Formal Disputes Pending Resolution	
Qualifications/ Definitions	Indicate the total number of formal provider claims disputes pending resolution at the end of each month on the last day of the reporting month. In subsequent months, this number should be reported until a resolution is determined under Item Number 3: "Total Number of Formal Provider Claims Disputes Pending From Previous Reporting Periods."
Formula	This number will auto-fill. OMPP will calculate quarterly and year-to-date activity using monthly data.
QR-P2 Report Log Data Elements	
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report log that supplements the Formal Provider Claims Disputes (QR-P2) Report. The MCO must submit the report to the monitoring contractor and OMPP by the last day of the month following the end of the reporting quarter. The MCO should submit a report log each reporting period using the previous reporting period's log but updated with the current reporting period provider claims disputes. The report log must include all provider claims disputes from reporting period to reporting period until the MCO completes the provider claims disputes process.
1. Reporting Period	
Qualifications/ Definitions	Enter the last month for which the MCO is reporting provider claims disputes data.
Formula	Enter in MM/YYYY format.
2. Provider Number	
Qualifications/ Definitions	Enter the provider's Indiana Health Care Program (IHCP) identification number.
Formula	Enter the IHCP provider number.

3. Provider Name	
Qualifications/ Definitions	Enter the names of providers who submitted a written formal provider claims dispute during the reporting quarter, whose formal provider claims dispute was pending determination as of the last day of the previous reporting period or whose formal claims dispute was resolved as of the last day of the current reporting period.
Formula	Enter last name, first name and middle initial.
4. Provider Type	
Qualifications/ Definitions	Enter the provider type as follows for each provider listed: <u>Provider Types:</u> Chiropractor Clinics/Health Department (not FQHC/RHC) Durable Medical Equipment Family Planning FQHC/RHC Home Health Hospital Laboratory Optometrist Other, identify Pharmacy Physician, other identify Physician, PMP Podiatrist Transportation
Formula	Select the appropriate provider type from the menu; if "Other, identify", limit type description to 25 alpha/numeric characters.
5. Date Received	
Qualifications/ Definitions	Insert the date the MCO received the written formal provider claims dispute.
Formula	Enter the date MM/DD/YYYY format. Note: This date must be January 1, 2005 or later.

6. Reason for Formal Dispute	
Qualifications/ Definitions	Briefly identify the issues prompting the formal provider claims disputes that were received during the reporting period.
Formula	Limit to 25 alpha/numeric characters.
7. Resolution Determination	
Qualifications/ Definitions	Indicate the status of the resolution and the party favored in the determination for all formal provider claims dispute issues received, resolved or pending resolution during the reporting quarter as of the last day of the reporting period using the following descriptions: <u>Resolution Determination Description</u> Determination favored MCO Determination favored Provider No determination was made as of the last day of the reporting period
Formula	Select the appropriate resolution description from the menu.
8. Resolution Description	
Qualifications/ Definitions	Enter a text description that briefly describes the resolution determination regarding the formal provider claims disputes resolved during the reporting quarter as of the last day of the reporting period.
Formula	Limit to 200 alpha/numeric characters.
9. Date Resolved	
Qualifications/ Definitions	Indicate the date the MCO notified the provider of the formal provider claims dispute resolution determination.
Formula	Enter the date in MM/DD/YYYY format. Note: This date must be January 1, 2005 or later. OMPP will calculate the number of calendar days to resolution by using "Date Received" and "Date Resolved" data.
10. Calendar Days To Resolve	
Qualifications/ Definitions	Calculate the number of calendar days from the date the MCO received the provider's formal claims dispute to the date the MCO notified the provider of its determination.
Formula	This field will auto-fill.

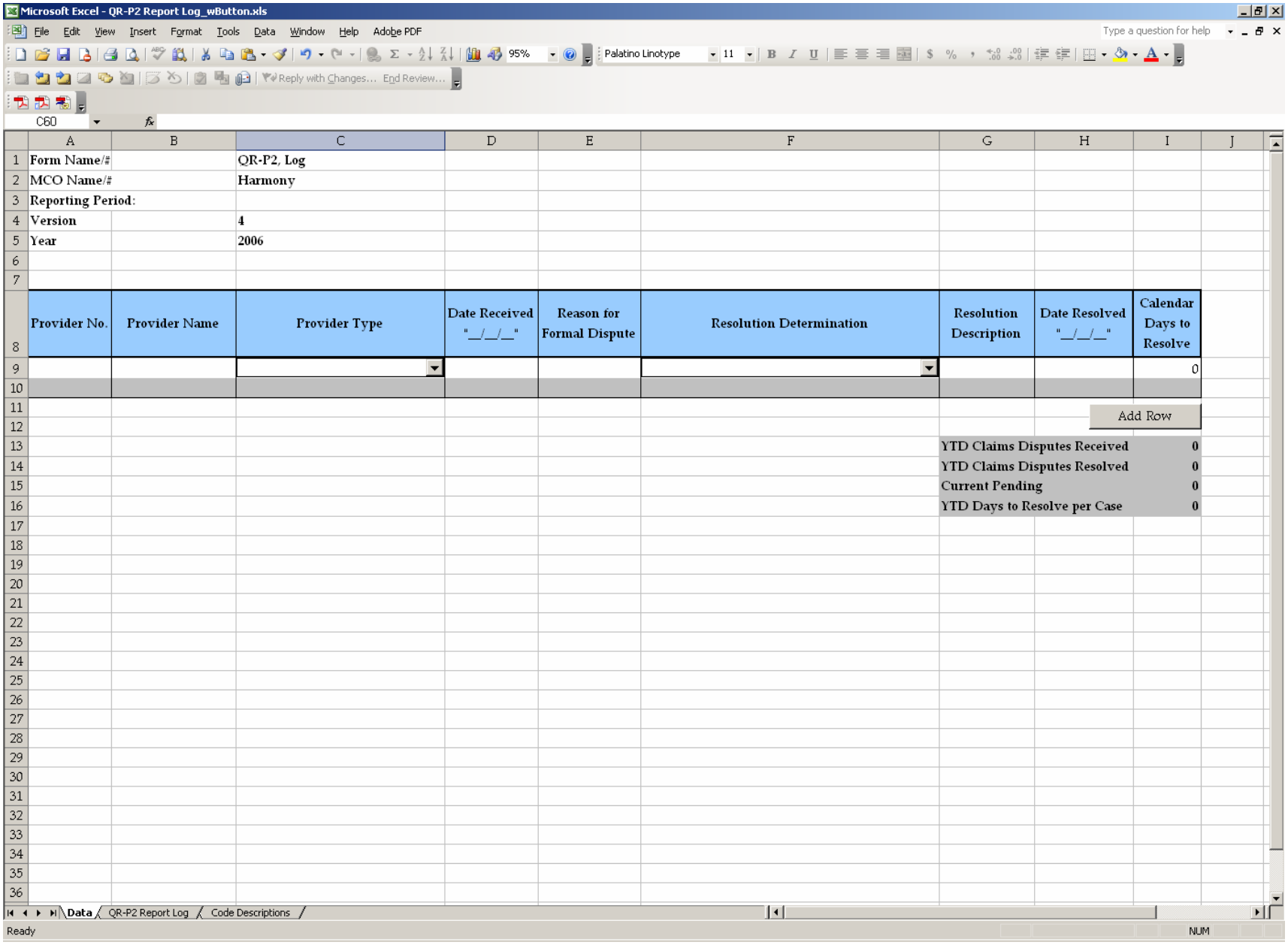
TABLE QR-P2: Formal Provider Claims Disputes Resolution Matrix

Issue	Final Policy
1. Definition of a formal claim dispute review (i.e., claims appeal).	• A process that provides a channel for providers to appeal a decision resulting from the informal provider claims dispute process.
2. Timeframe for submission of a request for a formal claim dispute resolution review.	• In the event the matter submitted for informal resolution is not resolved to the provider's satisfaction within 30 calendar days after the provider commences the informal claim resolution procedure, the provider shall have 60 calendar days from that point to submit a written request for the matter to be reviewed in the formal claims dispute process.
3. Timeframe for the MCO to acknowledge the receipt of a request for a formal claim review.	• The MCO must acknowledge receipt of a request for a formal claim review within five calendar days of the receipt of the request for a formal claim review.
4. Accountability for conducting formal claim dispute resolution procedure.	• A panel of one or more individuals selected by the MCO shall conduct the formal claim review.
5. Timeframe for the formal claim dispute resolution process.	• Within 45 calendar days after the commencement of the formal claims resolution procedure, the panel shall deliver to the provider the panel's written determination.
6. Notice of a formal claim dispute resolution to the provider of record.	• The MCO must notify the provider of the determination of a formal claim resolution review within five calendar days of the day a decision was reached. (Reference: Managed Care Provider Reimbursement Dispute Resolution, 405 IAC 1-1.6)
7. Reporting requirement.	• The MCO shall maintain a log of provider appeals involving claims. The log shall include the providers name, date of objection, nature of objection and disposition. The MCO shall submit quarterly reports to OMPP.



Form Name/#	QR-P2	
MCO Name/#	Harmony	
Reporting Period		
Version	4	
Year	2006	

Item	Data Description	Month 1	Month 2	Month 3
1	Total Number of Formal Disputes Received	0	0	0
2	Total Number of Formal Disputes Pending From Previous	0	0	0
3	Average Number of Days to Resolve All Formal Disputes	0	0	0
4	Number of Formal Disputes Resolved	0	0	0
5	Number of Formal Disputes Pending Resolution	0	0	0



Microsoft Excel - QR-P2 Report Log_wButton.xls

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2	MCO Name/#		Harmony							
3	Reporting Period:									
4	Version		4							
5	Year		2006							
6										
7										
8	Provider No.	Provider Name	Provider Type	Date Received "__/__/__"	Reason for Formal Dispute	Resolution Determination	Resolution Description	Date Resolved "__/__/__"	Calendar Days to Resolve	
9									0	
10										
11								Add Row		
12										
13							YTD Claims Disputes Received		0	
14							YTD Claims Disputes Resolved		0	
15							Current Pending		0	
16							YTD Days to Resolve per Case		0	
17										
18										
19										
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Data | QR-P2 Report Log | Code Descriptions

Ready

MCO name will be on the template.

MCO Name: _____

Reporting Period: _____

Reporting period will be on the template.

Indicate the number of all written formal disputes received during each month as of the last day of the reporting month.

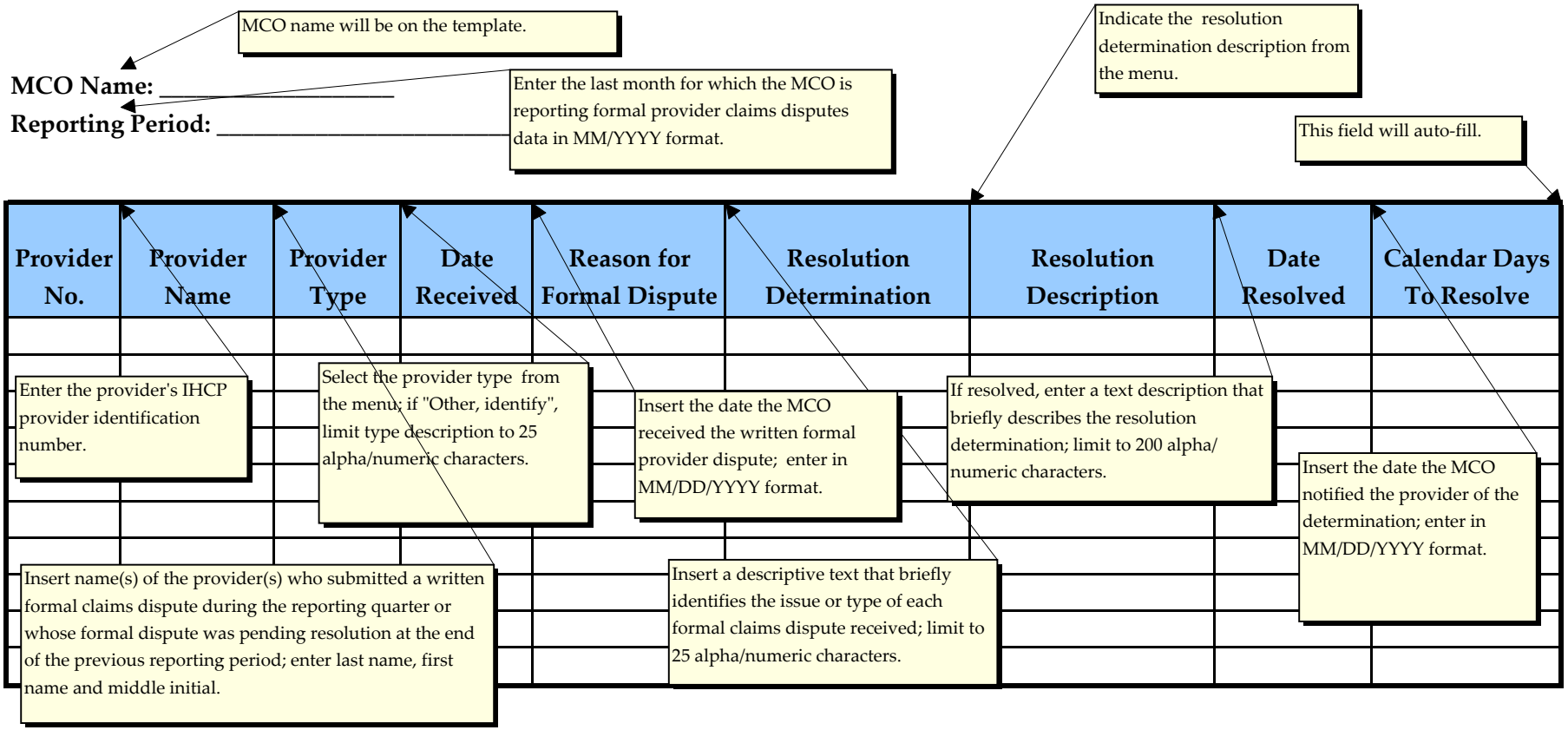
Item No.	Data Description	Month 1	Month 2	Month 3
1	Total Number of Formal Disputes Received			
2	Total Number of Formal Disputes Pending From Previous Reporting Periods			
3	Average Number of Days to Resolve All Formal Disputes			
4	Number of Formal Disputes Resolved			
5	Number of Formal Disputes Pending Resolution			

Insert the total number of formal disputes pending resolution at the end of the previous reporting month.

Indicate the length of time in calendar days to resolve all the formal disputes for each month as of the last day of each reporting month.

Indicate the total number of formal disputes resolved as of the last day of the reporting month.

This number will auto-fill. This number should be reported in subsequent months in Item 2 "Total Number of Formal Disputes Pending From Previous Reporting Periods" until resolution.


MCO name will be on the template.
MCO Name: _____
Reporting Period: _____
Enter the last month for which the MCO is reporting formal provider claims disputes data in MM/YYYY format.
Indicate the resolution determination description from the menu.
This field will auto-fill.
Provider No.
Provider Name
Provider Type
Date Received
Reason for Formal Dispute
Resolution Determination
Resolution Description
Date Resolved
Calendar Days To Resolve
Enter the provider's IHCP provider identification number.
Select the provider type from the menu; if "Other, identify", limit type description to 25 alpha/numeric characters.
Insert the date the MCO received the written formal provider dispute; enter in MM/DD/YYYY format.
If resolved, enter a text description that briefly describes the resolution determination; limit to 200 alpha/ numeric characters.
Insert the date the MCO notified the provider of the determination; enter in MM/DD/YYYY format.
Insert name(s) of the provider(s) who submitted a written formal claims dispute during the reporting quarter or whose formal dispute was pending resolution at the end of the previous reporting period; enter last name, first name and middle initial.
Insert a descriptive text that briefly identifies the issue or type of each formal claims dispute received; limit to 25 alpha/numeric characters.

Resolution Determination Descriptions

Determination favored MCO

Determination favored Provider

No determination was made as of the last day of the reporting period

Provider Types

Chiropractor

Clinics/Health Department (not FQHC/RHC)

Durable Medical Equipment

Family Planning

FQHC/RHC

Home Health

Hospital

Laboratory

Optometrist

Other, identify

Pharmacy

Physician, other identify

Physician, PMP

Podiatrist

Transportation

General Report Description	
QR-P3 Binding Arbitration	
Purpose	Monitor the volume and timely resolution of MCO binding arbitration requests from out-of-network providers quarterly by month.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is an ad hoc report. The MCO submits this report only when a provider dispute goes to binding arbitration. The MCO must submit this report to the monitoring contractor and OMPP within five business days of knowing a provider dispute is going to binding arbitration. After submitting the initial notification of the provider dispute going to binding arbitration, the MCO must submit this report quarterly until the binding arbitration decision is rendered and the provider is notified of the decision. This report must be submitted by the MCO for those binding arbitration requests received from providers who do not have an agreement in place (i.e., out-of-network) with the MCO describing a provider dispute process. The MCO must refer to Table QR-P3: Binding Arbitration Matrix (attached) for more information on the claims dispute policy, definitions and timeframes.
Performance Measures	OMPP has not indicated specific performance measures at this time.
QR-P3 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the reporting quarter for which binding arbitration request data is being submitted.
Formula	Select reporting period from menu.
2. Total Number of Binding Arbitrations Received	
Qualifications/ Definitions	Indicate the number of all binding arbitration requests received during the reporting quarter by month as of the last day of the reporting month.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.

3. Total Number of Binding Arbitrations Pending From Previous Reporting Periods	
Qualifications/ Definitions	Indicate the number of binding arbitration requests that were received in previous months and not resolved as of the last day of the previous month.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.
4. Average Number of Days to Resolve Binding Arbitrations	
Qualifications/ Definitions	Indicate resolution times in calendar days from the date the MCO received the binding arbitration request to the day the MCO notified the provider of a resolution determination.
Formula	Julian day of the date of the decision of the binding arbitration (-) Julian day of the date the MCO received the binding arbitration request = The number of days. Total number of calendar days to resolve all binding arbitration requests resolved in the month ÷ Total number of all binding arbitration resolved in the month = The average number of calendar days to resolve binding arbitrations in the month. OMPP will calculate quarterly and year-to-date activity using monthly data.
5. Number of Binding Arbitrations Resolved	
Qualifications/ Definitions	Indicate the total number of binding arbitration requests resolved in each month of the reporting quarter as of the last day of the month. OMPP considers a provider claims dispute to be resolved when the provider has been notified of the resolution decision. Until notification, OMPP considers the resolution to be pending.
Formula	Enter total numbers. OMPP will calculate quarterly and year-to-date activity using monthly data.

6. Number of Binding Arbitrations Pending Resolution	
Qualifications/ Definitions	Indicate the total number of binding arbitration requests pending resolution at the end of each month of the last day of the reporting month. In subsequent reports, this number should be reported until a resolution is determined under Item Number 3: "Total Number of Binding Arbitrations Pending From Previous Reporting Periods."
Formula	This number will auto-fill. OMPP will calculate quarterly and year-to-date activity using monthly data.
QR-P3 Report Log Data Elements	
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report log that supplements the Binding Arbitration (QR-P3) Report. The MCO must submit the report to the monitoring contractor and OMPP by the by the last day of the month following the end of the reporting quarter. The MCO should submit a report log each reporting period using the previous reporting period's log but updated with the current reporting period binding arbitration activity. The report log must include all binding arbitrations from reporting period to reporting period until the MCO completes the binding arbitration process.

1. Reporting Period	
Qualifications/ Definitions	Enter the last month for which the MCO is reporting binding arbitration data.
Formula	Enter in MM/YYYY format.

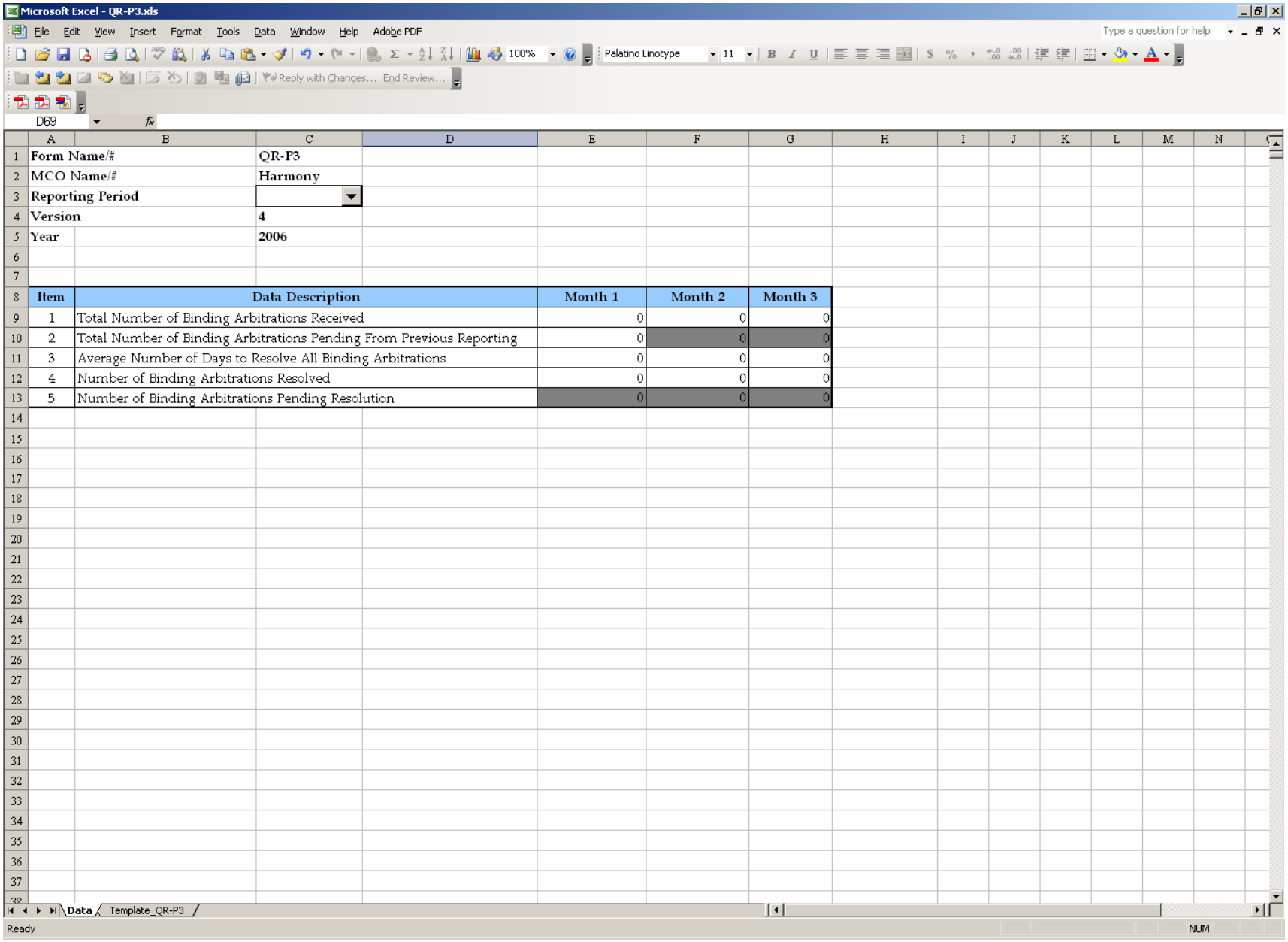
2. Provider Number	
Qualifications/ Definitions	Enter the provider's Indiana Health Care Program (IHCP) identification number for each provider whose binding arbitration request was received, pending resolution or resolved during the reporting quarter.
Formula	Enter the IHCP provider number.

3. Provider Name	
Qualifications/ Definitions	Enter the name(s) of provider(s) who submitted a binding arbitration request during the reporting quarter, whose binding arbitration request was pending determination as of the last day of the previous reporting period, or whose binding arbitration request was resolved as of the last day of the current reporting period.
Formula	Enter last name, first name and middle initial.
4. Provider Type	
Qualifications/ Definitions	Select the provider type as follows for each provider listed: <u>Provider Types</u> Chiropractor Clinics/Health Department (not FQHC/RHC) Durable Medical Equipment Family Planning FQHC/RHC Home Health Hospital Laboratory Optometrist Other, identify (specialist physicians, other providers) Pharmacy Physician, PMP Podiatrist Transportation Pharmacy
Formula	Select the appropriate provider type from the menu; if "Other, identify", limit type description to 25 alpha/numeric characters.
5. Date Received	
Qualifications/ Definitions	Insert the date the MCO received the binding arbitration request.
Formula	Enter the date MM/DD/YYYY format. Note: This date must be January 1, 2005 or later.

6. Reason for Binding Arbitration	
Qualifications/ Definitions	Briefly identify the issues prompting the binding arbitration requests that were received during the reporting quarter.
Formula	Limit to 25 alpha/numeric characters.
7. Resolution Determination	
Qualifications/ Definitions	Indicate the status of the resolution and the party favored in the determination for all binding arbitration requests received, resolved or pending resolution during the reporting quarter as of the last day of the reporting period using the following descriptions: <u>Resolution Determination Descriptions</u> Determination favored MCO Determination favored Provider No determination made as of the last day of the reporting period
Formula	Limit to 200 alpha/numeric characters.
8. Resolution Description	
Qualifications/ Definitions	Enter a text description that briefly describes the resolution determination regarding the binding arbitration requests resolved during the reporting quarter as of the last day of the reporting period.
Formula	Select the appropriate resolution description from the menu.
9. Date Resolved	
Qualifications/ Definitions	Indicate the date the provider was notified of the binding arbitration resolution determination.
Formula	Enter the date in MM/DD/YYYY format. Note: This date must be January 1, 2005 or later. OMPP will calculate the number of days to resolution using the "Date Received" and "Date Resolved" data.
10. Calendar Days To Resolve	
Qualifications/ Definitions	Calculate the number of calendar days from the date the MCO received the provider's binding arbitration request to the date the MCO notified the provider of its determination.
Formula	This field will auto-fill.

TABLE QR-P3: Binding Arbitration Matrix

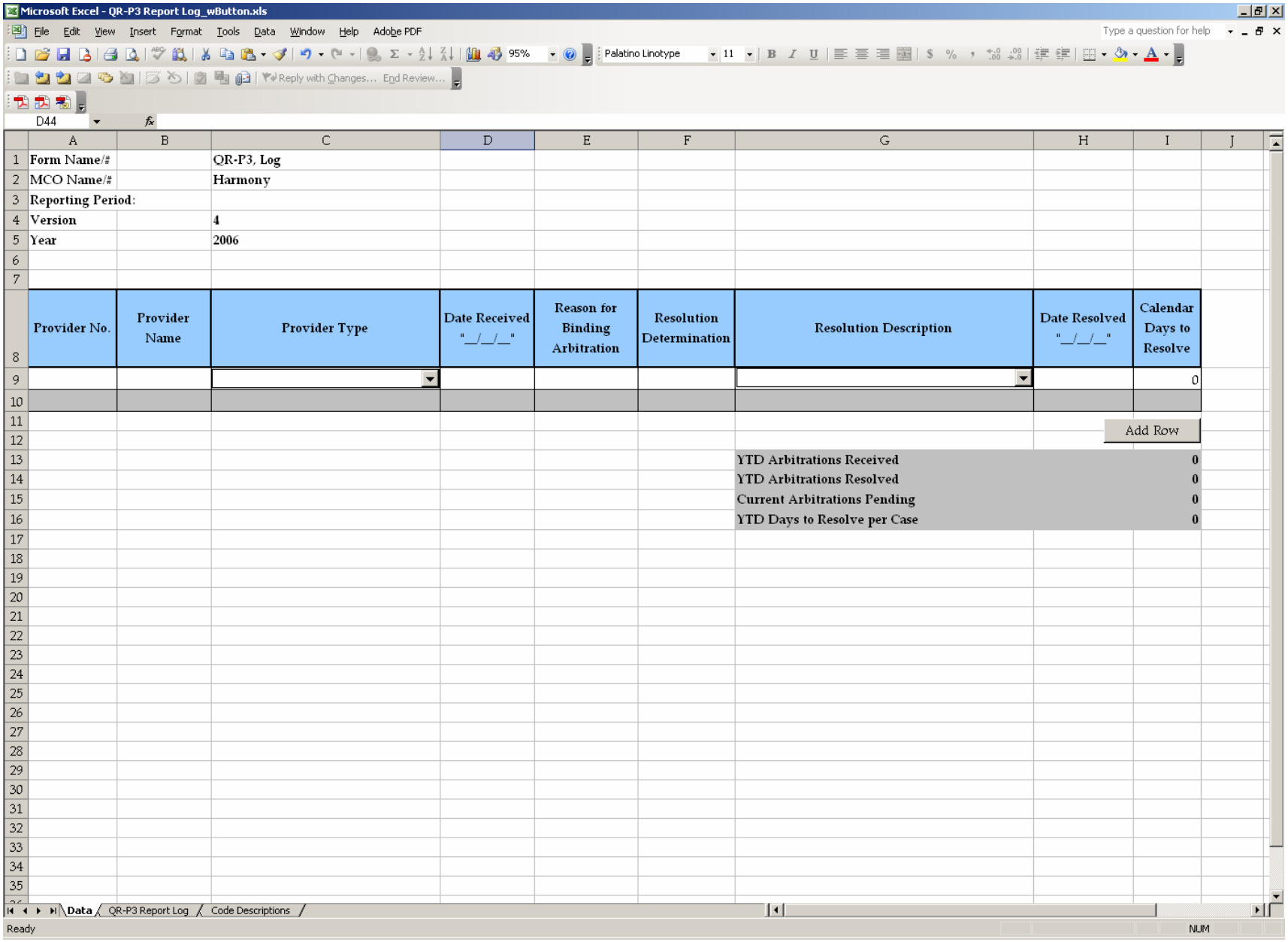
Issue	Final Policy
1. Definition of binding arbitration.	• A process conducted in accordance with the rules and regulations of the American Health Lawyers Association pursuant to the Uniform Arbitration Act as adopted in the State of Indiana at IC 34-57-2, unless the provider and the MCO mutually agree to some other binding resolution procedure or other statutorily imposed procedures apply.
2. Timeframe for processing of claim after final determination from binding arbitration resolution process.	• A claim that is finally determined through the MCO's claim dispute resolution process (including arbitration) to lack sufficient supporting documentation shall be processed by the MCO within 30 calendar days of receiving the supporting documentation from the provider. If the claim does not lack sufficient supporting documentation, the MCO shall process the provider's claims within 30 calendar days of the binding arbitration determination.
3. Reporting requirement.	• The MCO shall maintain a log of the binding arbitrations. The log shall include the provider's name, date of objection, nature of objection and disposition. The MCO shall submit quarterly reports to OMPP.



Microsoft Excel - QR-P3.xls

Form Name/#	QR-P3	
MCO Name/#	Harmony	
Reporting Period		
Version	4	
Year	2006	

Item	Data Description	Month 1	Month 2	Month 3
1	Total Number of Binding Arbitrations Received	0	0	0
2	Total Number of Binding Arbitrations Pending From Previous Reporting	0	0	0
3	Average Number of Days to Resolve All Binding Arbitrations	0	0	0
4	Number of Binding Arbitrations Resolved	0	0	0
5	Number of Binding Arbitrations Pending Resolution	0	0	0



Microsoft Excel - QR-P3 Report Log_wButton.xls

	A	B	C	D	E	F	G	H	I	J
1	Form Name/#		QR-P3, Log							
2	MCO Name/#		Harmony							
3	Reporting Period:									
4	Version		4							
5	Year		2006							
6										
7										
8	Provider No.	Provider Name	Provider Type	Date Received "__/__/__"	Reason for Binding Arbitration	Resolution Determination	Resolution Description	Date Resolved "__/__/__"	Calendar Days to Resolve	
9									0	
10										
11										
12										
13							YTD Arbitrations Received		0	
14							YTD Arbitrations Resolved		0	
15							Current Arbitrations Pending		0	
16							YTD Days to Resolve per Case		0	

Add Row

Data | QR-P3 Report Log | Code Descriptions

Ready

MCO name will be on the template.

MCO Name: _____

Reporting Period: _____

The reporting month will be on the template.

Item No.	Data Description	Month 1	Month 2	Month 3
1	Total Number of Binding Arbitrations Received			
2	Total Number of Binding Arbitrations Pending From Previous Reporting Periods			
3	Average Number of Days to Resolve All Binding Arbitrations			
4	Number of Binding Arbitrations Resolved			
5	Number of Binding Arbitrations Pending Resolution			

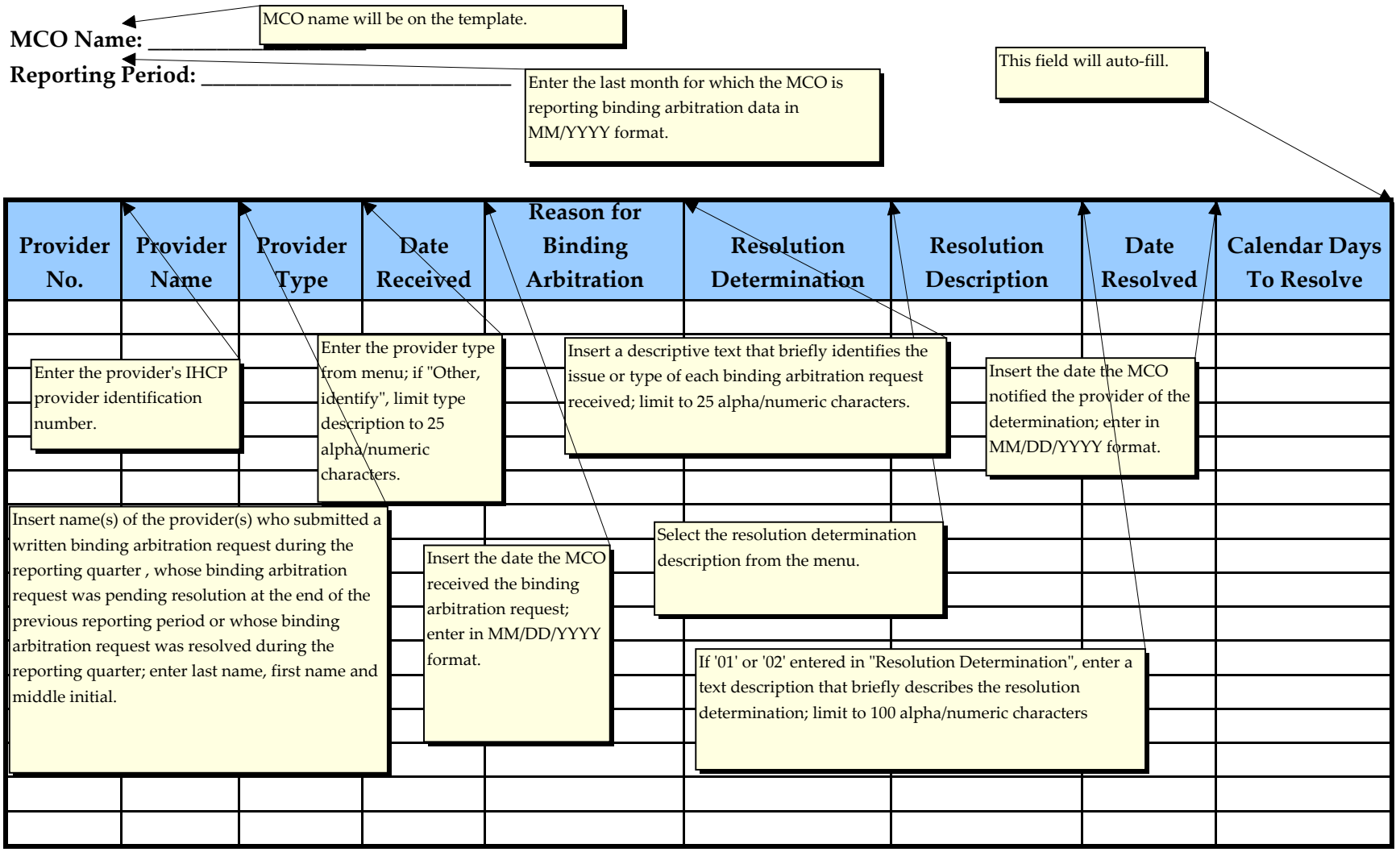
Indicate the number of all written binding arbitrations received during each month as of the last day of the reporting month.

Insert the total number of binding arbitrations pending resolution at the end of the previous reporting month.

Indicate the length of time in calendar days to resolve all binding arbitrations for each month.

Indicate the total number of binding arbitrations resolved as of the last day of the reporting month.

This number will auto-fill. This number should be reported in subsequent months in Item 2 "Total Number of Binding Arbitrations Pending From Previous Reporting Periods" until resolution.


MCO Name: _____
MCO name will be on the template.
Reporting Period: _____
Enter the last month for which the MCO is reporting binding arbitration data in MM/YYYY format.
This field will auto-fill.
Provider No.
Provider Name
Provider Type
Date Received
Reason for Binding Arbitration
Resolution Determination
Resolution Description
Date Resolved
Calendar Days To Resolve
Enter the provider's IHCP provider identification number.
Enter the provider type from menu; if "Other, identify", limit type description to 25 alpha/numeric characters.
Insert a descriptive text that briefly identifies the issue or type of each binding arbitration request received; limit to 25 alpha/numeric characters.
Insert the date the MCO notified the provider of the determination; enter in MM/DD/YYYY format.
Insert name(s) of the provider(s) who submitted a written binding arbitration request during the reporting quarter , whose binding arbitration request was pending resolution at the end of the previous reporting period or whose binding arbitration request was resolved during the reporting quarter; enter last name, first name and middle initial.
Insert the date the MCO received the binding arbitration request; enter in MM/DD/YYYY format.
Select the resolution determination description from the menu.
If '01' or '02' entered in "Resolution Determination", enter a text description that briefly describes the resolution determination; limit to 100 alpha/numeric characters

Resolution Determination Descriptions

Determination favored MCO

Determination favored Provider

No determination was made as of the last day of the reporting period

Provider Types

Chiropractor

Clinics/Health Department (not FQHC/RHC)

Durable Medical Equipment

Family Planning

FQHC/RHC

Home Health

Hospital

Laboratory

Optometrist

Other, identify (specialist physicians, other providers)

Pharmacy

Physician, PMP

Podiatrist

Transportation

General Report Description	
QR-Q1 Quality Management and Improvement Committee Meetings' Minutes	
Purpose	Review the issues the MCO is addressing during its internal quality management and improvement committee meetings and evaluate the correlation of internal committee activities to the MCO's quality management and improvement work plan goals.
Required Submission Type	Narrative text.
Comments/ Recommendations	The MCO should provide the Quality Management and Improvement Committee meeting minutes for all committee meetings that occurred in a reporting quarter for OMPP's review during on-site monitoring visits. The MCO needs to only provide minutes from all Quality Management and Improvement meetings specific to the Hoosier Healthwise program.
Performance Measures	OMPP has not indicated specific performance measures at this time.
QR-Q1 Data Elements	
1. All Data Elements	
Qualifications/ Definitions	Narrative text on the meeting's minutes must include: • MCO name • Name of committee • Date of meeting • Names and position titles of attendees • Subcommittees, work groups or task force reports or updates • Agenda items • Narrative description of agenda items, issues, discussion, planned actions, follow-up, responsible party, dates due, problem resolution, next steps, etc. • Date of next scheduled meeting
Formula	MCO's choice of narrative format but must include required elements.

General Report Description	
QR-Q2 Medical Necessity Review Log	
Purpose	Monitor the volume and timely resolution of the MCO's medical necessity review requests; monitor the medical necessity denial volume and identify any potential issues related to the interpretation of medical necessity.
Required Submission Type	Excel template
Comments/ Recommendations	The MCO should provide the data elements described below for review upon OMPP's request during on-site monitoring visits. OMPP is providing an optional Excel template for the MCO's use if the MCO does not have another format that can provide similar information. A member's provider (or member) may request (or submit claims for) services that require the MCO's Medical Director to make a medical necessity determination for physical health care services or benefits. This report uses the member identification as the reference point for the medical necessity review information rather than provider identification. For purposes of this report, OMPP's use of the term "Medical Director" can be interpreted as any licensed physician-reviewer employed by the MCO to confirm or deny the medical necessity of requested health care services or benefits. The MCO should identify medical necessity review requests and determinations for special needs and Package C members separately.
Performance Measures	OMPP has not indicated specific performance measures at this time.
QR-Q2 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the calendar year and reporting period for which the MCO is presenting its medical necessity review information.
Formula	Indicate the reporting period.

2. Number of Medical Necessity Review Determinations Requested	
Qualifications/ Definitions	Identify the number of medical necessity reviews (i.e., authorizations) the MCO's staff referred to its Medical Director(s) during the reporting period to confirm medical necessity for physical health care services or benefits for the first time (i.e., for the member-provider combination date and type of service). These reviews may be prior to services being rendered (i.e., prior authorization), concurrent reviews or retroactive reviews.
Formula	Enter whole number.
3. Number of Medical Necessity Determinations Pending from Previous Reporting Periods	
Qualifications/ Definitions	Identify the number of medical necessity determination reviews requested for the first time (i.e., for the member-provider combination date and type of service) that had not been completed by the last day of the previous reporting period. A medical necessity determination is recognized as complete after the MCO notifies the provider (or member) of the Medical Director's determination.
Formula	Enter a whole number.
4. Number of Medical Necessity Denials Determined	
Qualifications/ Definitions	Identify the number of medical necessity determination reviews that were considered for the first time (i.e., for the member-provider combination date and type of service) and completed during the reporting period that resulted in the Medical Director's denial of the requested or rendered service.
Formula	Enter a whole number.
5. Number of Medical Necessity Denials Submitted for Reconsideration	
Qualifications/ Definitions	Insert the number of medical necessity denials that the MCO received for reconsideration (i.e., appeal) during the reporting period.
Formula	Enter a whole number.
6. Number of Medical Necessity Denials Submitted for Reconsideration Pending from Previous Reporting Period	
Qualifications/ Definitions	Insert the number of medical necessity denials that the MCO received for reconsideration (i.e., appeal) but were pending determination (i.e., member or provider was not notified of a determination) as of the last day of the previous reporting period.
Formula	Enter a whole number.

7. Number of Medical Necessity Denials Reconsidered and Overturned	
Qualifications/ Definitions	Insert the number of medical necessity denials that the MCO's Medical Director reconsidered and resulted in the original denial decision being overturned during the reporting period.
Formula	Enter a whole number.
8. Tracking Number	
Qualifications/ Definitions	For all medical necessity determination reviews completed in the reporting period that result in a denial of the services requested or rendered, provide a unique identifier to track the provider's (member's) requested or rendered service. Use the same unique identifier (i.e., the member's RID) for that provider's (member's) requested or rendered service throughout the review determination and any subsequent appeals processes. However, the member tracking number can be any alpha/numeric code that the MCO assigns to the member for the purposes of reporting <u>all</u> member grievances and appeals related to one individual issue for that member.
Formula	MCO may determine any alpha/numeric specific identifier; limit 25 characters.
9. Member Indicator	
Qualifications/ Definitions	Identify the type of member whose services were denied using the indicator descriptions as follows: <u>Member Indicator</u> General member Package C member Special needs member
Formula	Indicate the member indicator from the code description options.
10. Date Received	
Qualifications/ Definitions	Identify the date the MCO's staff received the request for services. For prior authorization or concurrent reviews, enter the date the MCO received the request from the provider (or member). For retrospective reviews, enter the date the claim was received or the request for services was received by the MCO, whichever date is first.
Formula	Enter date in MM/DD/YY format.

11. Type of Service Reviewed	
Qualifications/ Definitions	Identify the type of health care service that was denied by using the following: <u>Type of Service</u> Ambulatory/Outpatient surgical procedures Durable medical equipment Emergency room visits Home health visits Inpatient hospital admissions Inpatient hospital continued stays Medical supplies Occupational therapy - outpatient Office visit - consultations Other, identify Physical therapy - outpatient Speech therapy - outpatient
Formula	Select the type of service from the code descriptions options; if "Other, identify", limit the description to 25 alpha/numeric characters.
12. Provider Type	
Qualifications/ Definitions	Identify the provider type that requested or rendered the services that were denied by using the following: <u>Provider Types</u> Chiropractor Clinics/Health Department (not FQHC/RHC) Durable Medical Equipment Family Planning FQHC/RHC Home Health Hospital (Continued on the next page.)

Qualifications/ Definitions (Continued)	(Continued from the previous page.) Provider Types Laboratory Optometrist Other, identify Pharmacy Physician, other identify Physician, PMP Podiatrist Transportation
Formula	Select the type of provider from the code description options; if "Other, identify", limit the description to 25 alpha/numeric characters.
13. Place of Service	
Qualifications/ Definitions	Indicate the place of service for the health care service that was denied using the following: Place of Service Ambulance Ambulatory Surgical Center Birthing Center Emergency Room - Hospital Federally Qualified Health Center Home Inpatient Hospital Laboratory Nursing Facility Office Other, identify (Continued on the next page.)

Qualifications/ Definitions (Continued)	(Continued from the previous page.) Outpatient Hospital Rehabilitation Facility - Inpatient Rehabilitation Facility - Outpatient Rural Health Clinic Skilled Nursing Facility Urgent Care Facility
Formula	Select the place of service from the code description options; if "Other, identify", limit the description to 25 alpha/numeric characters
14. Expedited Request	
Qualifications/ Definitions	Identify the health care service request as "expedited" when the member or provider expressed a clinically urgent situation when submitting the request for approval or reconsideration.
Formula	Select an appropriate affirmative or negative response from the code descriptions options.
15. Date of Determination	
Qualifications/ Definitions	Identify the date the MCO notified the provider (or member) of the medical necessity denial. If the MCO had not notified the provider (or member) of its medical necessity denial determination or reconsideration (i.e., appeal) determination as of the last day of the reporting period, leave this field blank and include the review request in subsequent reports until a notification of the determination is completed.
Formula	Enter date in MM/DD/YY format.
16. Description of Denial Reason	
Qualifications/ Definitions	Briefly describe the reason the Medical Director indicated for the medical necessity denial determination.
Formula	Limit to 200 alpha/numeric characters.

Enter MCO's name on the template.

MCO Name

Reporting Period_____

Insert the reporting period MM/DD/YY format.

Item No.	Medical Necessity Review Activity	Quarter Total
1	Number of Medical Necessity Review Determinations	
2	Number of Medical Necessity Determinations Pending from Previous Reporting Periods	
3	Number of Medical Necessity Denials Determined	
4	Number of Medical Necessity Denials Submitted for Reconsideration	
5	Number of Medical Necessity Denials Submitted for Reconsideration Pending from Previous Reporting Periods	
6	Number of Medical Necessity Denials Reconsidered and Overturned	

Insert the number of requests for medical necessity reviews that the MCO received for the first time (i.e., for that member - provider combination, date and type of service) during the reporting period.

Insert the number of medical necessity requests that the MCO received that were submitted for the first time (i.e., for that member - provider combination, date and type of service) but were pending determination (i.e., member or provider was not notified of a determination) as of the last day of the previous reporting period.

Insert the number of medical necessity determinations that the MCO's Medical Director considered for the first time (i.e., for that member -provider combination, date and type of service) and resulted in a denial during the reporting period.

Insert the number of medical necessity denials that the MCO received for reconsideration (i.e., appeal) during the reporting period.

Insert the number of medical necessity denials that the MCO received for reconsideration (i.e., appeal) but were pending determination (i.e., member or provider was not notified of a determination) as of the last day of the previous reporting period.

Insert date that MCO notified member or provider of the determination in MM/DD/YY format; leave blank if the MCO did not notify the member or provider of the denial as of the last day of the reporting period and list this request in subsequent reports until determination notice.

Select member indicator from the code descriptions options.

Insert the number of medical necessity denials that the MCO's Medical Director reconsidered and resulted in the original denial decision being overturned during the reporting period.

Select the place of service from the code descriptions options.

Tracking Number	Member Indicator	Type of Medical Necessity Review	Date Received	Type of Service Reviewed	Provider Type	Place of Service	Expedited Request	Date of Determination	Description of Denial Reason

For all medical necessity determination reviews completed in the reporting period that resulted in a denial, enter a tracking number (e.g., the member RID) for the member that will be used throughout the request, determination, and appeals processes related to this review.

Insert the type of review from the code description options.

Insert date the MCO submitted the review request to the Medical Director for a medical necessity determination in MM/DD/YY format.

Select the type of service from the code descriptions options.

Select the type of provider from the code descriptions options.

Select "YES" if the request was expedited; select "NO" if the request was not expedited.

Type of Service
Ambulatory/Outpatient surgical procedures
Durable medical equipment
Emergency room visits
Home health visits
Inpatient hospital admissions
Inpatient hospital continued stays
Medical supplies
Occupational therapy - outpatient
Office visit - consultations
Other, identify
Physical therapy - outpatient
Speech therapy - outpatient

Place of Service
Ambulance
Ambulatory Surgical Center
Birthing Center
Emergency Room-Hospital
Federally Qualified Health Center
Home
Inpatient Hospital
Laboratory
Nursing Facility
Office
Other, identify
Outpatient Hospital
Rehabilitation Facility - Inpatient
Rehabilitation Facility - Outpatient
Rural Health Clinic
Skilled Nursing Facility
Urgent Care Facility

Member Indicator
General member
Package C member
Special needs member

Type of Medical Necessity Review
Concurrent Review
Other, identify
Prior Authorization Review
Retrospective Review

Provider Types
Chiropractor
Clinics/Health Department (not FQHC/RHC)
Durable Medical Equipment
Family Planning
FQHC/RHC
Home Health
Hospital
Laboratory
Optometrist
Other, identify
Pharmacy
Physician, other identify
Physician, PMP
Podiatrist
Transportation

General Report Description	
AN-Q1 Quality Management and Improvement Work Plan	
Purpose	Describe the MCO's goals, strategies and tasks for improving the delivery of health care benefits and services to its Hoosier Healthwise members.
Required Submission Type	Word template. The MCO can modify the template by adding additional rows for information related to the data fields, but should not change basic template format.
Comments/ Recommendations	This is a prospective annual work plan. The MCO must submit its prospective work plan to the monitoring contractor and OMPP by March 1st of each calendar year for all goals except the HEDIS® work plan. The MCO's prospective HEDIS work plan, included in the AN-Q1, is due each calendar year by September 1st and should build on the outcomes of the previous year's HEDIS results. The MCO must update its HEDIS work plan quarterly as directed by OMPP. This work plan also provides additional fields to update the MCO's progress throughout the year. OMPP may request progress updates at anytime to any or all goals. However, the MCO must update its work plan in its entirety (including HEDIS progress) and submit the updated work plan to the monitoring contractor and OMPP by January 31st of each subsequent calendar year.
Performance Measures	OMPP has not indicated specific performance measures at this time.
AN-Q1 Data Elements	
1. Managed Care Organization (MCO)	
Qualifications/ Definitions	Enter the name of the MCO submitting the work plan.
Formula	Not applicable.

2. MCO Project Point Person	
Qualifications/ Definitions	Indicate the name of the primary contact for the Quality Management and Improvement Plan. This contact person internally coordinates the Quality Management and Improvement Plan activities, solicits updates to the plan's goals from other MCO staff, submits the Quality Management and Improvement Plan (AN-Q1) to OMPP and the monitoring contractor, and responds to OMPP's or the monitoring contractor's questions.
Formula	Enter last name, first name and middle initial.
3. Reporting Period	
Qualifications/ Definitions	Indicate the calendar year in which the MCO's activities will take place.
Formula	Enter in YYYY format.
4. Work Plan Goals	
Qualifications/ Definitions	Identify the high-level primary work plan goals the MCO has set to address its strategy for improving the delivery of health care benefits and services to its Hoosier Healthwise members. MCO's work plan goals must be strategic or long-term in nature and the MCO must identify objective measurements for assessing improvement or determining success in meeting the stated goals. The MCO must have the minimum number of work plan goals for each functional area as indicated below. OMPP may increase or decrease the number of goals it will require for any of the functional areas and may direct the MCO to include goals to address other areas for improvement. 1. Administrative: minimum of two goals, MCO's choice 2. Covered benefits: minimum of two goals, MCO's choice 3. Member services: minimum of two goals, MCO's choice 4. Provider network services: minimum of two goals, one goal must address network recruitment efforts for PMPs and required specialty providers (Continued on the next page.)

Qualifications/ Definitions (Continued)	(Continued from the previous page.) 5. Quality and utilization management: minimum of four goals, one must address HEDIS and one must address program integrity (Note: OMPP is providing the Program Integrity Incident Reporting Form in the MCO Policies and Procedures Manual.) 6. Management information systems: minimum of two goals, one must address shadow claims 7. Performance reporting: minimum of two goals, MCO's choice OMPP encourages the MCO to have more than the minimum number of goals and allows the MCO to add new goals or modify its goals at any time during the calendar year.
Formula	Identify the minimum high-level primary goals for each functional area as OMPP directs.
5. MCO CEO's Signature and Date	
Qualifications/ Definitions	Obtain CEO's signature and date signature as confirmation that the CEO is aware of the MCO's goals for improving the delivery of health care benefits and services to its Hoosier Healthwise members and supports the use of MCO resources to meet these goals. The CEO signature also confirms the CEO agrees the Quality Management and Improvement Plan goals are consistent with the MCO's and OMPP's strategic goals and that the CEO is holding appropriate staff accountable for their responsibilities toward meeting the goals outlined in the work plan. The MCO must submit the MCO CEO's signature for each work plan update that OMPP requests.
Formula	Not applicable.
6. Objectives	
Qualifications/ Definitions	List the objectives the MCO has established to address each of its high-level, primary work plan goals (Item 4). Each objective must include an objective measurement to assess improvement towards meeting the stated goal. For each high-level, primary work plan goal (Item 4), the MCO must have at least two objectives. The MCO may add new objectives at any time during the calendar year.
Formula	Identify a minimum of two objectives per high-level primary work plan goal.

7. Tasks	
Qualifications/ Definitions	Describe the major activities the MCO will implement to meet each objective. The MCO may add new tasks at any time during the calendar year. For each objective, the MCO must list at least two tasks.
Formula	Identify a minimum of two tasks per each objective.
8. Subtasks	
Qualifications/ Definitions	Describe additional activities the MCO will engage in to complete each task. The MCO is not required to list subtasks for each task. However, the MCO must complete the MCO Task Contact, Target Completion Date, Potential Barriers, Actual Completion Date, Encountered Barriers and Status fields on the reporting template for each task or subtask listed for each objective.
Formula	Not applicable.
9. MCO Task Contact	
Qualifications/ Definitions	Name the person(s) responsible for each task or subtask. This may be a different contact name than the person identified in Item 2 as the "MCO Project Point Person."
Formula	Enter last name, first name and middle initial.
10. Target Completion Date	
Qualifications/ Definitions	State the date the MCO plans to complete the task or subtask.
Formula	Enter date in MM/DD/YY format.
11. Potential Barriers	
Qualifications/ Definitions	Describe any limitations the MCO anticipates that might impede its ability to meet any or all high-level primary work plan goals or objectives. Describe these barriers at the task and subtask levels. The MCO must include plans to manage barriers and identify any assistance that OMPP could provide in managing barriers.
Formula	Not applicable.

12. Actual Completion Date	
Qualifications/ Definitions	State the date the MCO completed the task or subtask during the reporting period. If the completion date is more than 30 calendar days beyond the Target Completion Date, the MCO should discuss the reasons for the delay in the Status column. If the MCO has not completed the task or subtask at the time the MCO submits an update, the MCO should leave this field blank, indicate the reasons for any delay (if applicable) in the Status field.
Formula	Enter date in MM/YY format.
13. Encountered Barriers	
Qualifications/ Definitions	Describe any limitations or challenges the MCO encountered that hindered the MCO's ability to meet any high-level primary work plan goals or objectives. The MCO should discuss encountered barriers as the barrier applies to tasks or subtasks. The MCO must include actions it has taken to manage barriers and identify any assistance that OMPP provided in managing barriers.
Formula	Not applicable.
14. Status	
Qualifications/ Definitions	Provide an update on tasks and subtasks related to each high-level, primary work plan goal and objective. Whenever possible, the MCO should quantify the data in the Status column and provide detail describing the activity (e.g., "Trained 10 executive staff members on the details of the program integrity plan for 2 hours," versus "Trained staff"). When appropriate, the MCO should list and describe the next steps it anticipates implementing to meet the goals or objectives.
Formula	Not applicable.

Quality Management and Improvement Work Plan
MANAGED CARE ORGANIZATION:
MCO PROJECT POINT PERSON:
WORK PLAN SUBMISSION DATE:
1.0 – ADMINISTRATIVE FUNCTIONAL AREA
WORK PLAN GOAL: 1.1 -
WORK PLAN GOAL: 1.2 -
2.0 – COVERED BENEFITS FUNCTIONAL AREA
WORK PLAN GOAL: 2.1 -
WORK PLAN GOAL: 2.2 -
3.0 – MEMBER SERVICES FUNCTIONAL AREA
WORK PLAN GOAL: 3.1 -
WORK PLAN GOAL: 3.2 -
4.0 – PROVIDER NETWORK SERVICES FUNCTIONAL AREA
WORK PLAN GOAL: 4.1 -
WORK PLAN GOAL: 4.2 -
5.0 – QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT FUNCTIONAL AREA
WORK PLAN GOAL: 5.1 -
WORK PLAN GOAL: 5.2 -
WORK PLAN GOAL: 5.3 -
WORK PLAN GOAL: 5.4 -

6.0 – MANAGEMENT INFORMATION SYSTEMS FUNCTIONAL AREA
WORK PLAN GOAL: 6.1 -
WORK PLAN GOAL: 6.2 -
7.0 – PERFORMANCE REPORTING FUNCTIONAL AREA
WORK PLAN GOAL: 7.1 -
WORK PLAN GOAL: 7.2 -
MCO CEO'S SIGNATURE AND DATE:

FUNCTIONAL AREA: 1.0 - Administrative							
WORK PLAN GOAL: 1.1 -							
OBJECTIVE: 1.1 A -							
1.1 A Task 1 -							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
1.1 A Task 2 -							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

OBJECTIVE: 1.1.B -							
1.1.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
1.1.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 1.2 -							
OBJECTIVE: 1.2.A -							
1.2.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

1.2.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 1.2.B -							
1.2.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
1.2.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

FUNCTIONAL AREA: 2.0 – Covered Benefits							
WORK PLAN GOAL: 2.1 -							
OBJECTIVE: 2.1.A -							
2.1.A Task 1 -							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
2.1.A Task 2 -							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

OBJECTIVE: 2.1.B -							
2.1.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
2.1.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 2.2 -							
OBJECTIVE: 2.2.A -							
2.2.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

2.2.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 2.2.B -							
2.2.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
2.2.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

FUNCTIONAL AREA: 3.0 – Member Services							
WORK PLAN GOAL: 3.1 -							
OBJECTIVE: 3.1.A -							
3.1.A Task 1 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
1a.							
1b.							
1c.							
3.1.A Task 2 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
2a.							
2b.							
2c.							

OBJECTIVE: 3.1.B -							
3.1.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
3.1.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 3.2 -							
OBJECTIVE: 3.2.A -							
3.2.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

3.2.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 3.2.B -							
3.2.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
3.2.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

FUNCTIONAL AREA: 4.0 – Provider Network Services							
WORK PLAN GOAL: 4.1 -							
OBJECTIVE: 4.1.A -							
4.1.A Task 1 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
1a.							
1b.							
1c.							
4.1.A Task 2 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
2a.							
2b.							
2c.							

OBJECTIVE: 4.1.B -							
4.1.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
4.1.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 4.2 -							
OBJECTIVE: 4.2.A -							
4.2.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

4.2.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 4.2.B -							
4.2.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
4.2.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

FUNCTIONAL AREA: 5.0 – Quality Management and Utilization Management							
WORK PLAN GOAL: 5.1 -							
OBJECTIVE: 5.1.A -							
5.1.A Task 1 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
1a.							
1b.							
1c.							
5.1.A Task 2 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
2a.							
2b.							
2c.							
OBJECTIVE: 5.1.B -							
5.1.B Task 1 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
1a.							
1b.							
1c.							

5.1.B Task 2 -							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 5.2 -							
OBJECTIVE: 5.2.A -							
5.2.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
5.2.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

OBJECTIVE: 5.2.B -							
5.2.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
5.2.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 5.3 -							
OBJECTIVE: 5.3.A -							
5.3.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

5.3.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 5.3.B -							
5.3.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
5.3.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

WORK PLAN GOAL: 5.4 -							
OBJECTIVE: 5.4.A -							
5.4.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
5.4.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**		**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 5.4.B -							
5.4.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

5.4.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

FUNCTIONAL AREA: 6.0 – Management Information Systems							
WORK PLAN GOAL: 6.1 -							
OBJECTIVE: 6.1.A -							
6.1.A Task 1 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
1a.							
1b.							
1c.							
6.1.A Task 2 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
2a.							
2b.							
2c.							

OBJECTIVE: 6.1.B -							
6.1.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
6.1.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 6.2 -							
OBJECTIVE: 6.2.A -							
6.2.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

6.2.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 6.2.B -							
6.2.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
6.2.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

FUNCTIONAL AREA: 7.0 – Performance Reporting							
WORK PLAN GOAL: 7.1 -							
OBJECTIVE: 7.1.A -							
7.1.A Task 1 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
1a.							
1b.							
1c.							
7.1.A Task 2 -							
No.	Subtask	MCO Task Contact	Target Completion Date	Potential Barriers	Actual Completion Date	Encountered Barriers	Status
2a.							
2b.							
2c.							

OBJECTIVE: 7.1.B -							
7.1.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
7.1.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
WORK PLAN GOAL: 7.2 -							
OBJECTIVE: 7.2.A -							
7.2.A Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							

7.2.A Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							
OBJECTIVE: 7.2.B -							
7.2.B Task 1:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
1a.							
1b.							
1c.							
7.2.B Task 2:							
No.	**Subtask**	**MCO Task Contact**	**Target Completion Date**	**Potential Barriers**	**Actual Completion Date**	**Encountered Barriers**	**Status**
2a.							
2b.							
2c.							

General Report Description	
AN-Q2 Health Plan Employer Data and Information Set (HEDIS®) Data Submission Tool (DST)	
Purpose	Evaluate the MCO's data compiled for its annual Health Plan Employer Data and Information Set (HEDIS®) audit survey.
Required Submission Type	The Certified HEDIS® Compliance Auditor's (CHCA's) final locked electronic DST form, per the National Committee for Quality Assurance (NCQA) Annual HEDIS® format.
Comments/ Recommendations	This is an annual report. The MCO must submit this report to the monitoring contractor and OMPP by June 15th, per the NCQA schedule, for the preceding calendar year's data. The MCO must submit the CHCA's final locked electronic DST to the monitoring contractor and OMPP. Additional information about this report can be found on the NCQA website regarding "NCQA HEDIS® Data Submission Tool" at: http://www.ncqa.org/Programs/HEDIS.
Performance Measures	OMPP has not indicated specific performance measures at this time.
AN-Q2 Data Elements	
1. All Data Elements	
Qualifications/ Definitions	Insert the requested information into the NCQA DAT provided on the NCQA website at: http://www.ncqa.org/Programs/HEDIS/.
Formula	Use NCQA DAT.

General Report Description	
AN-Q3 Health Plan Employer Data and Information Set (HEDIS®) Baseline Assessment Tool (BAT)	
Purpose	Assess the health plan's ability to accurately and completely collect and report HEDIS® data.
Required Submission Type	Word template per the National Committee for Quality Assurance (NCQA) Annual Health Plan Employer Data and Information Set (HEDIS®) Baseline Assessment Tool format.
Comments/ Recommendations	This is an annual report. The MCO must submit this report to its contracted Certified HEDIS® Compliance Auditor (CHCA) by the date designated by the Auditor. In addition, the MCO must submit the report to the monitoring contractor and OMPP by January 31st or by the date the report is due to the MCO's contracted CHCA. Additional information about this report can be found on the NCQA website at: http://www.ncqa.org/Programs/HEDIS/Audit "NCQA HEDIS® Compliance Audit Baseline Assessment Tool (BAT)."
Performance Measures	OMPP has not indicated specific performance measures at this time.
AN-Q3 Data Elements	
1. All Data Elements	
Qualifications/ Definitions	Insert the requested information into the NCQA document provided on the NCQA website at http://www.ncqa.org/Programs/HEDIS/Audit.
Formula	Use NCQA document.

General Report Description	
AN-Q4 Health Plan Employer Data and Information Set (HEDIS®) Compliance Auditor's Final Report	
Purpose	Assess the MCO's compliance with the Health Plan Employer Data and Information Set (HEDIS®) Technical Specifications reporting requirements when reporting annual HEDIS® rates.
Required Submission Type	HEDIS® Auditor's final audit report, as submitted to the health plan from the Auditor.
Comments/ Recommendations	This is an annual report. The MCO must submit this report to the monitoring contractor and OMPP by July 31st of each calendar year with the second quarter's non-financial report submissions.
Performance Measures	OMPP has not indicated specific performance requirements at this time.
AN-Q4 Data Elements	
1. All Data Elements	
Qualifications/ Definitions	Submit Auditor's final report.
Formula	Not applicable.

<table>
<tr><th colspan="2">General Report Description</th></tr>
<tr><td colspan="2">AN-Q5 Asthma Common Measures Report</td></tr>
<tr><td>Purpose</td><td>Monitor MCO's management of members with asthma as defined by modified Health Plan Employer Data and Information Set (HEDIS®) Technical Specifications and definitions.</td></tr>
<tr><td>Required Submission Type</td><td>Excel in MCO's choice of format.</td></tr>
<tr><td>Comments/ Recommendations</td><td>This is an annual report with quarterly updates. The MCO must submit this report to the monitoring contractor and OMPP per the following schedule:
<table>
<tr><th>Date Due</th><th>Data</th><th>MCOs</th></tr>
<tr><td>March 15, 2006</td><td>CY 2004</td><td>Legacy MCOs</td></tr>
<tr><td>June 15, 2006</td><td>Q1-05 (Jan-Mar)
Q4-05 (Oct-Dec)</td><td>All MCOs</td></tr>
<tr><td>September 15, 2006</td><td>Q2-05 thru Q1-06</td><td>All MCOs</td></tr>
<tr><td>December 15, 2006</td><td>Q3-05 thru Q2-06</td><td>All MCOs</td></tr>
<tr><td>March 15, 2007</td><td>Q4-05 thru Q3-06</td><td>All MCOs</td></tr>
<tr><td>June 15, 2007</td><td>Q1-06 thru Q4-06</td><td>All MCOs</td></tr>
<tr><td>September 15, 2007</td><td>Q2-06 thru Q1-07</td><td>All MCOs</td></tr>
</table></td></tr>
<tr><td>Performance Measures</td><td>OMPP has not indicated specific performance requirements at this time.</td></tr>
<tr><th colspan="2">AN-Q5 Data Elements</th></tr>
<tr><td colspan="2">1. All Data Elements</td></tr>
<tr><td>Qualifications/ Definitions</td><td>Submit report data as requested in Table AN-Q5 (attached).</td></tr>
<tr><td>Formula</td><td>Not applicable.</td></tr>
</table>

Table AN-Q5: Asthma Common Measures

INDIANA BCAP-FINAL **California, New York State and Indiana Asthma Collaborative** **Definitions of Common Measures** **Using "Modified" HEDIS** **July 28, 2005**	
Notes	• These Common Measures definitions are based on the HEDIS definitions for CY 2004/HEDIS 2005. • No continuous enrollment requirement for measurement categories I (asthma prevalence) and II (asthma utilization per year). • Annual changes in HEDIS specifications for coding (diagnoses, services, pharmacy, and exclusions) will be incorporated by the participants into the modified HEDIS definition each year. Other changes that are made in the HEDIS specifications each year will NOT be incorporated into these Common Measures. • The lag time for the data will be three months. Therefore, the data should be run and reported along with the regular HEDIS cycle in the year following the close of the measurement year. • Since we want the data to be as comparable as possible over time, please do NOT use the option to exclude members diagnosed with COPD or emphysema (Table E15-C).
I. Asthma Prevalence	
Product Line	Medicaid line of business only
Ages	The measure should be reported for each member who is the specified age on 12/31 of the measurement year. • Under age 2 *(Indiana Only)* • 2 – 4 year-olds • 5 – 9 year-olds • 10 – 17 year-olds • 18 – 56 year-olds • 57 years and older *(Indiana Only)* • All ages

<table>
<tr><td>Ethnic/Racial Groups

<u>(Not applicable for Indiana ONLY. State does not provide ethnicity information for enrollees)</u>

(100% of the population is accounted for)</td><td>• Hispanic/Latino/a
• White
• African American/Black
• Asian/Pacific Islanders
• American Native</td><td>• Other (total of all not listed individually, including “unknown”)</td></tr>
<tr><td>Numerator for the Prevalence Measure</td><td colspan="2">To identify all members with asthma, use all applicable coding schemes (i.e., count members that meet the criteria for any one of the approaches below).</td></tr>
<tr><td>Step 1</td><td colspan="2">Identify members as having asthma who had any of the following:

• At least one Emergency Department (ED) visit with asthma (ICD-9 code 493) as any diagnosis (primary, secondary, tertiary) in the measurement year

• At least one acute inpatient discharge with asthma as any diagnosis (primary, secondary, or tertiary) in the measurement year

• At least two outpatient asthma visits in 12 months with asthma as any of the listed diagnoses in the measurement year

• At least two asthma medication dispensing events in 12 months in the measurement year

A dispensing event is one prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days’ supply by 30 and roundup to convert. For example, a 100-day prescription is equal to 4 dispensing events (100/30 = 3.33, rounded down to 3). In addition, two different prescriptions dispensed on the same day are counted as two different dispensing events.</td></tr>
<tr><td>Step 2</td><td colspan="2">For a member identified as having asthma because of at least two asthma medication dispensing events, and leukotriene modifiers were the sole asthma medication dispensed, the member must:

• Meet any one of the other three criteria, or

• Have at least one diagnosis of asthma in any setting</td></tr>
</table>

Codes to Identify Emergency Department and Inpatient Asthma Encounters

Note: These codes are from HEDIS Table E15-A for the calendar year 2005. You will have to update this table for use with the 2006 and 2007 HEDIS data as noted in the "Notes" section above.

Description	CPT Codes	UB-92 Revenue Codes
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291, 99292, 99356, 99357	10X–16X, 20X–22X, 987, 72X, 80X
ED services	99281-99285, 99288	981, 450, 451, 452, 459
Outpatient visit	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99271-99275	510, 516-517, 520, 521, 523, 76X, 456, 515,526, 770, 779, 982, 983, 988

NDC Codes for Asthma Medications

NCQA will provide a comprehensive list of NDC codes for the appropriate numerator and denominator asthma medications on its Web site at www.ncqa.org each year. Be sure to use the codes appropriate to each year.

Denominator for the Prevalence Measure	The total eligible population on the last day (12/31) of the measurement year, as defined by the same product line, ages, and ethnic/racial groups shown for the numerator above. No continuous enrollment is required.

II. Asthma Utilization Per Year	
Ages	Total population including all ages
• **Asthma-Related Hospital Admissions Per Year, Per 1,000 Members**	
Numerator	12,000 x total number of hospital admissions with a primary inpatient diagnosis of asthma (493.xx) in the measurement year. **Indiana only: Observation (hospital setting under 72 hours) AND inpatient admissions should be summed to create one numerator for this measure.** **A second, separate numerator should be created for a second version of this measure with inpatient days ONLY, and not including the observation days.**
Denominator	Total number of member months for all members in Medicaid for the measurement year. **No continuous enrollment requirement.**

• **Asthma-Related Hospital Days Per Year, Per 1,000 Members**	
Numerator	12,000 x total number of hospital days with a primary inpatient diagnosis of asthma (493.xx) in the measurement year. **Indiana only: Observation (hospital setting under 72 hours) AND inpatient days should be summed to create one numerator for this measure.** **A second, separate numerator should be created for a second version of this measure with inpatient days ONLY, and not including the observation days.**
Denominator	Total number of member months for all members in Medicaid for the measurement year. **No continuous enrollment requirement.**
• **Asthma-Related Emergency Department Visits Per Year, Per 1,000 Members**	
Numerator	12,000 x total number of emergency department visits that did not result in a hospitalization with a primary diagnosis of asthma (493.xx) in the measurement year.
Denominator	Total number of member months for all members in Medicaid for the measurement year. **No continuous enrollment requirement.**
III. Asthma Utilization Per Year per 1000 Members with Persistent Asthma	
Notes	Use strict HEDIS criteria for the denominators.
Ages	The measure should be reported by age groups for members who are the specified ages on 12/31 of the measurement year. • 5 – 9 year-olds • 10 – 17 year-olds • 18 – 56 year-olds • Aggregate rate for all three age groups **Continuous enrollment is required.**

• **Asthma-Related Hospital Admissions per Year, per 1000 Members with Persistent Asthma**	
Numerator	For members in the denominator, the total number of hospital admissions with a primary inpatient diagnosis of asthma (493.xx) in the measurement year. **Indiana only: Observation (hospital setting under 72 hours) AND inpatient admissions should be summed to create one numerator for this measure.** **A second, separate numerator should be created for a second version of this measure with inpatient days ONLY, and not including the observation days.**
Denominator	Identify the population with persistent asthma using the HEDIS definition (i.e. members who met diagnosis criteria in the prior year and remain eligible during the measurement year). **Continuous enrollment is required.**
• **Asthma-Related Hospital Days Per Year, per 1000 Members with Persistent Asthma**	
Numerator	For members in the denominator, the total number of hospital days for admissions with a primary inpatient diagnosis of asthma (493.xx) in the measurement year. **Indiana only: Observation (hospital setting under 72 hours) AND inpatient days should be summed to create one numerator for this measure.** **A second, separate numerator should be created for a second version of this measure with inpatient days ONLY, and not including the observation days.**
Denominator	Identify the members with persistent asthma using the HEDIS definition (i.e. members who met diagnosis criteria in the prior year and remain eligible during the measurement year). **Continuous enrollment is required.**

• **Asthma-Related Emergency Department Visits Per Year, per 1000 Persistent Members with Asthma**	
Numerator	For members in the denominator, the total number of emergency department visits that did not result in an hospitalization with a primary diagnosis of asthma (493.xx) in the measurement year.
Denominator	Identify members with persistent asthma using the HEDIS definition (i.e. members who met diagnosis criteria in the prior year and remain eligible during the measurement year). **Continuous enrollment is required.**
IV. Appropriate Use of Medications	
• **HEDIS Measure: Use of Appropriate Medications for People with Asthma**	
Note	Report the numerators and denominators from the measurement year's HEDIS report
Product Line	Medicaid line of business only
Ages	• 5 – 9 year-olds • 10 – 17 year-olds • 18 – 56 year-olds • Aggregate rate for all three age groups
Numerator	Administrative data as reported to HEDIS
Denominator	Administrative data as reported to HEDIS. **Continuous enrollment is required.**

• **Utilization of Short-Acting Beta Agonists (Based on California Department of Health Services Measure)**	
Note	Report the numerators and denominators from the measurement year.
Product Line	Medicaid line of business only
Ages	• 5 – 9 year-olds • 10 – 17 year-olds • 18 – 56 year-olds • Aggregate rate for all three age groups
Numerator	The number of Medicaid enrollees who filled prescriptions for eight or more canisters of inhaled short-acting beta-agonist during the measurement year. Note that more than one canister may be dispensed on a given date and each canister will be counted separately.
Denominator	Administrative data as reported to HEDIS for "Use of Appropriate Medications for People with Asthma." **Continuous enrollment is required.**

General Report Description	
SA-CRCS-1 Capitation Rate Calculation Sheet	
Purpose	To monitor the MCO's utilization rates and costs. Comparisons may be made among the categories of service, across rate categories and regions.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a semi-annual report. The MCO should submit cumulative year-to-date data each reporting period. The Capitation Rate Calculation Sheet (CRCS) report is based on those services with dates of service during the reporting period (i.e., the experience period) and for which the claims were paid, no later than 90 calendar days after the end of the reporting period (i.e., the lag period). The MCO must submit this report to the monitoring contractor and OMPP no later than 45 calendar days after the lag period (i.e., approximately 135 calendar days after the end of the experience period). Example 1, Reporting period #1 - Experience period (dates of service) – January 1st through June 30th; Lag period (claims paid for services incurred during experience period) – January 1st through September 30th; Report due date – November 15th. Example 2, Reporting period #2 - Experience period (dates of service) – January 1st through December 31st; Lag period (claims paid for services incurred during experience period) – January 1st (reporting year) through March 31st (next year); Report due date – May 15th. The MCO must submit a separate Excel file for each package (i.e., A, B and C) by each rate category for each region and one Excel file for each rate category statewide. OMPP is providing a specific template for each combination and named for that combination. The matrix below provides the alpha indicators that OMPP has used in naming the files. (Continued on the next page.)

Comments/ Recommendations (Continued)	(Continued from the previous page.) Benefit Package Categories AB=Packages A and B C=Package C Region Categories N=North Region C=Central Region S=South Region I=Indiana Statewide Rate Categories N=Newborns P=Preschoolers C=Children A=Adolescents M=Adult males F=Adult females For example: SA-CRCS-1-ABNN.xls would be the file name for CRCS data for Benefit Package A/B, North Region, Newborns Rate Category and SA-CRCS-1-CCC.xls would be the file name for CRCS data for Benefit Package C, Central Region, Children Rate Category.
Performance Measures	OMPP has not indicated specific performance measures at this time.
SA-CRCS-1 Data Elements	
1. Reporting (Experience) Period	
Qualifications/ Definitions	Indicate the reporting period for the year-to-date results, based on the experience date, i.e., date of service.
Formula	Select the reporting (experience) period range from the menu.
2. Benefit Package	
Qualifications/ Definitions	Select the template for a specific benefit package, region and rate category to which the data applies. The MCO must submit a separate Excel sheet for each package by each rate category for each region and statewide. Benefit Packages Package A/B (Temporary Assistance for Needy Families, Children's Health Insurance Program-Phase I and pregnant women) Package C (Children's Health Insurance Program-Phase II)
Formula	Select the specific template for the benefit package combination.

3. Region	
Qualifications/ Definitions	Select the template for a specific region, benefit package and rate category to which the data applies. The MCO must submit a separate Excel sheet for each benefit package by each rate category for each region and statewide. <u>Regions</u> North Central South Indiana Statewide
Formula	Select the specific template for the region combination.
4. Rate Category	
Qualifications/ Definitions	Select the template for a specific rate category, benefit package and region to which the data applies. The MCO must submit a separate Excel sheet for each benefit package by each rate category for each region. <u>Rate Categories</u> Newborns Adolescents Preschoolers Adult males Children Adult females
Formula	Select the specific template for the rate category combination.
5. Member Months	
Qualifications/ Definitions	Identify the total cumulative number of member months reported year-to-date for each rate category by benefit package and region of the State. This number should be specific to the data being reported on each worksheet.
Formula	Calculate the total number of member months for the reporting period by adding together the number of Hoosier Healthwise members enrolled on the 15th day of each month in the reporting period.

6. Category of Service	
Qualifications/ Definitions	Enter the sum of covered services for the following categories of service. Refer to Table SA-CRCS-1 for procedure code ranges. <u>Category of Services</u> Inpatient Hospital Medical/Surgical/Non-Delivery Maternity Well Newborn Other Inpatient Outpatient Hospital Emergency Room Other Outpatient Pharmacy Prescription Drugs/OTC Drugs Ancillaries Transportation DME, Home Health, Other Ancillary Physician Inpatient and Outpatient Surgery Office Visits/Consults Well Baby Exams/Physical Exams Hospital Inpatient Visits Emergency Room Visits Radiology/Pathology Self Referral Other Professional
Formula	Enter data per service category.
7. Annual Utilization per 1,000	
Qualifications/ Definitions	Identify the reported annual utilization rate per 1,000 member months for each service category specific to the benefit package, rate category and region selected.
Formula	Enter the total number for each service category and total all numbers in the row titled "Sum of Covered Services:" (Total number of units/Member months for the period) x 12,000

8. Amount Paid per Unit	
Qualifications/ Definitions	Identify the total net dollar amount paid for each unit of service specific to the benefit package, rate category and regions selected.
Formula	Enter the total amount paid for each service category and total all numbers in the row titled "Sum of Covered Services:" Total net cost/Total number of units
9. Net Medical Cost PMPM	
Qualifications/ Definitions	Identify the net medical cost (i.e., the service cost) per member per month specific to the benefit package, rate category and regions selected.
Formula	Enter the total cost for each service category and total all numbers in the row titled "Sum of Covered Services:" ([Annual utilization rate per 1,000] x [Paid per unit])/12,000
10. Completion Factor	
Qualifications/ Definitions	Insert a number (i.e., completion factor) that would represent a multiplier used to increase the incurred claim per member per month claim cost values shown in the report. The completion factor may illustrate in aggregate for all categories of service (i.e., the same value would appear on each category of service line) or may vary by category of service (i.e., a separate value would be illustrated for hospital inpatient services, hospital outpatient, etc.).
Formula	1 + [(Incurred but not reported reserve + In course settlement reserve)/(Claims paid to date for incurred dates of service)]

TABLE SA-CRCS-1: Categories of Service and Procedure Code Ranges

Type of Service	AP-DRGs	Medicare DRGs
Inpatient Hospital		
IP Medical/Surgical/Non-Delivery Maternity	0001 - 0369	0001 - 0002
	0376 - 0390	0006 - 0213
	0392 - 0424	0216 - 0220
	0439 - 0468	0223 - 0230
	0471 - 0585	0232 - 0369
	0587 - 0628	0376 - 0390
	0630 - 0634	0392 - 0399
	0636 - 0641	0401 - 0424
	0700 - 0708	0439 - 0455
	0710 - 0740	0461 - 0468
	0752	0471
	0755 - 0798	0473
	0800 - 0809	0475 - 0513
		0515 - 0540
IP Well Newborn	0391	0391
	0629	
Other Inpatient	0000	
	0425 - 0438	0425 - 0433
	0469 - 0470	0469 - 0470
	0586	
	0635	
	0636 - 0638	
	0709	
	0799	
	0810 - 0828	
	0999	

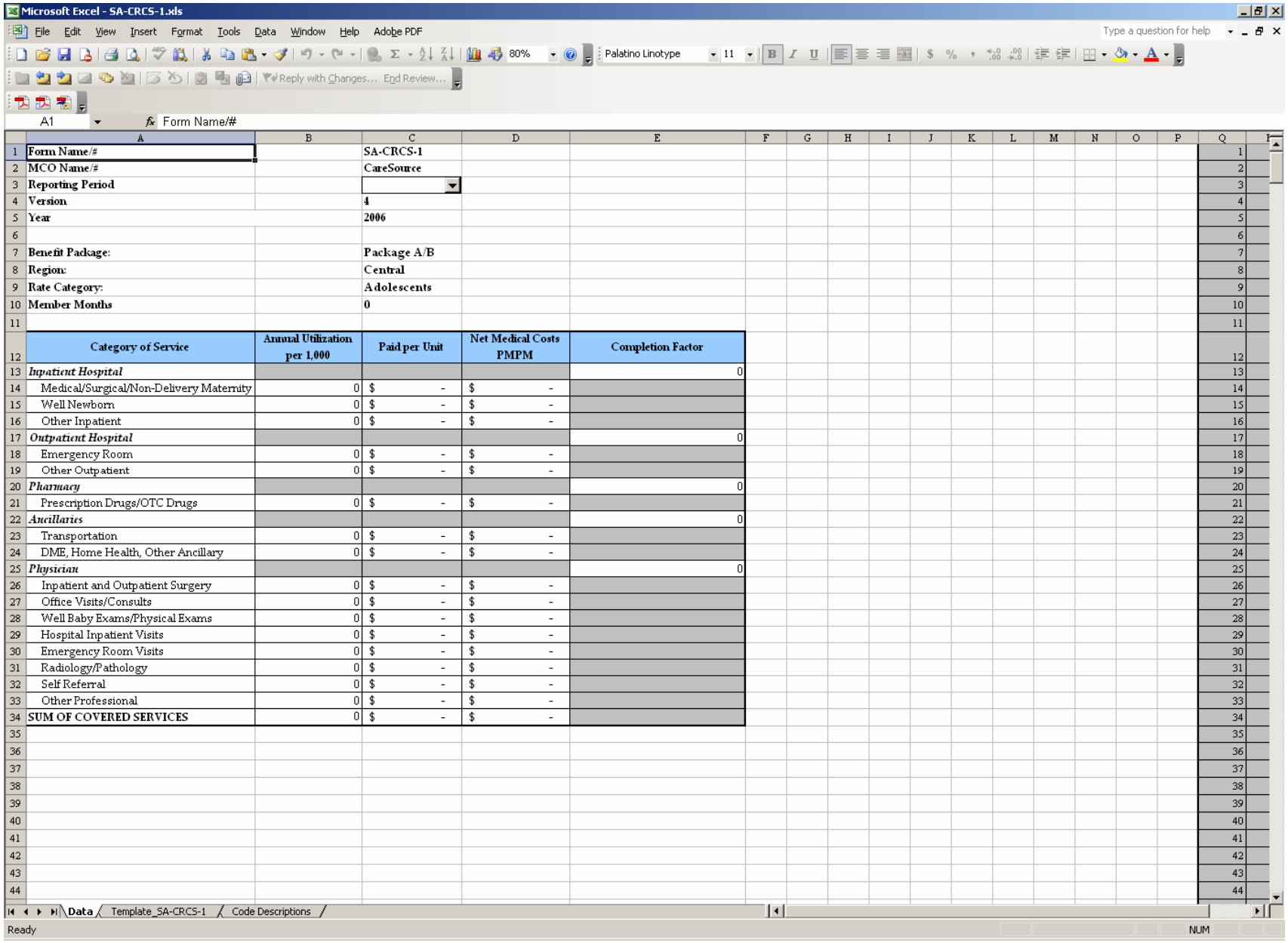
Type of Service	Revenue Code
Outpatient Hospital	
Emergency Room	450 -459
	981
Other Outpatient	000 - 449
	460 - 539
	550 - 569
	610 - 980
	982 - 999

Type of Service	CPT – 4 / HCPCS Code	Provider Type
Pharmacy		
Prescription Drugs	All Prescription Drugs Dispensed	
Ancillaries		
Transportation	A0001 -A0999	Or any services provided by a Transportation Provider and not assigned by CPT-4/ HCPCS methodology or not Provider Type Specific
	Q3019 - Q3020	
	T2001 - T2007	
	T2049	
DME, Home Health, Other Ancillary	92393	Or any services provided by DME, Home Health, and Other Ancillary Providers and not assigned by CPT-4/ HCPCS methodology or not Provider Type Specific
	99500 -99600	
	A4206 - A8999	
	A9000 - A9300	
	A9500 - A9700	
	A9900 -A9999	
	B4000 - B9999	
	E0100 - E9999	
	G0000 - G9999	
	K0000 - K9999	
	L0000 - L4999	
	Q0000 - Q0016	
	Q0117 - Q0123	
	Q0124 - Q9940	
	S6497 - S6523	
	S8185 - S8490	
	S8999 - S9022	
	S9024 - S9034	
	S9208 - S9379	
	S9490 - S9810	
	T1021	
	T2101 - T5999	
	V2620 - V2629	
	V5335 - V5336	

Type of Service	CPT – 4 / HCPCS Code	Provider Type
Physician		
Inpatient and Outpatient Surgery	10000 - 36414	Excludes anesthesiologist services
	36416 - 58999	
	59525	
	60000 -69000	
	92982 - 92992	
	93501 - 93536	
	93561 - 93562	
Office Visits/Consults	90000 - 90080	
	90100 - 90170	
	90400 - 90470	
	98900 - 98922	
	99201 - 99215	
	99241 - 99275	
	99321 -99355	
	99356 - 99359	
	99361 - 99376	
	99499	
Well Baby Exams/Physical Exams	90750 - 90753	
	90760 - 90764	
	90774	
	90778	
	99381 -99387	
	99391 - 99393	
	99401 - 99429	
	99432	

Type of Service	CPT – 4 / HCPCS Code	Provider Type
Hospital Inpatient Visits	90200 - 90292	
	90300 - 90370	
	90816 - 90829	
	99150 - 99151	
	99175 - 99195	
	99217 - 99239	
	99291 - 99292	
	99295 - 99297	
	99301 -99313	
	99356 - 99357	
	99360	
	99431	
	99433	
	99435	
	99438	
	99440	
Emergency Room Visits	99281 - 99288	
Radiology/Pathology	70000 - 89999	
	P0000 - P9999	
	R0000 - R5999	
Self Referral	92002 - 92392	Or any services provided by a Chiropractic, Podiatric and Eye Care Providers
	92395 - 92396	
	92499	
	98940 - 98943	
	V0000 - V2999	

Type of Service	CPT – 4 / HCPCS Code	Provider Type
Other Professional	00000 - 09999	Or any services provided by Other Professional Providers and not assigned by CPT-4/ HCPCS methodology or not Provider Type Specific. Also, includes services performed by an Anesthesiologist.
	36415	
	90476 -90749	
	90754	
	90780 - 90799	
	90801 - 90815	
	90830 - 90899	
	90900 - 90915	
	90918 - 91299	
	92502 - 92981	
	92993 - 93350	
	93539 - 93556	
	93579 - 97999	
	98925 - 98929	
	99000 - 99142	
	99170 - 99173	
	99199	
	99293 - 99294	
	99298 - 99300	
	99314 - 99316	
	99436	
	99450 - 99455	
	99999	
	D0000 - D9999	
	H5160	
	H5200 - H5300	
	J0110 - J9999	
	V5000 - V5999	



Microsoft Excel - SA-CRCS-1.xls

	A	B	C	D	E
1	**Form Name/#**		**SA-CRCS-1**		
2	**MCO Name/#**		**CareSource**		
3	**Reporting Period**				
4	**Version**		**4**		
5	**Year**		**2006**		
6					
7	**Benefit Package:**		**Package A/B**		
8	**Region:**		**Central**		
9	**Rate Category:**		**Adolescents**		
10	**Member Months**		**0**		
11					
12	**Category of Service**	**Annual Utilization per 1,000**	**Paid per Unit**	**Net Medical Costs PMPM**	**Completion Factor**
13	***Inpatient Hospital***				0
14	Medical/Surgical/Non-Delivery Maternity	0	$ -	$ -	
15	Well Newborn	0	$ -	$ -	
16	Other Inpatient	0	$ -	$ -	
17	***Outpatient Hospital***				0
18	Emergency Room	0	$ -	$ -	
19	Other Outpatient	0	$ -	$ -	
20	***Pharmacy***				0
21	Prescription Drugs/OTC Drugs	0	$ -	$ -	
22	***Ancillaries***				0
23	Transportation	0	$ -	$ -	
24	DME, Home Health, Other Ancillary	0	$ -	$ -	
25	***Physician***				0
26	Inpatient and Outpatient Surgery	0	$ -	$ -	
27	Office Visits/Consults	0	$ -	$ -	
28	Well Baby Exams/Physical Exams	0	$ -	$ -	
29	Hospital Inpatient Visits	0	$ -	$ -	
30	Emergency Room Visits	0	$ -	$ -	
31	Radiology/Pathology	0	$ -	$ -	
32	Self Referral	0	$ -	$ -	
33	Other Professional	0	$ -	$ -	
34	**SUM OF COVERED SERVICES**	0	$ -	$ -	

Data | Template_SA-CRCS-1 | Code Descriptions

Ready

MCO name will be on the template.

MCO Name_____

Select the reporting (experience) period range from the menu.

Reporting Period_____

The benefit package will be identified on the template.

Benefit Package:_____

The region will be identified on the template.

Region:_____

The rate category will be identified on the template.

Rate Category:_____

Insert the number of cumulative year-to-date member months.

Category of Service	Annual Utilization per 1,000	Paid per Unit	Net Medical Cost PMPM	Completion Factor
Inpatient Hospital				
Medical/Surgical/Non-Delivery Maternity	Admits/Days			
Well Newborn	Admits/Days			
Other Inpatient	Admits/Days			
Outpatient Hospital				
Emergency Room	Services			
Other Outpatient	Services			
Pharmacy				
Prescription Drugs/OTC Drugs	Scripts			
Ancillaries				
Transportation	Runs			
DME, Home Health, Other Ancillary	Services			
Physician				
Inpatient and Outpatient Surgery	Procedures			
Office Visits/Consults	Visits			
Well Baby Exams/Physical Exams	Exams			
Hospital Inpatient Visits	Visits			
Emergency Room Visits	Visits			
Radiology/Pathology	Procedures			
Self Referral	Services			
Other Professional	Services			
SUM OF COVERED SERVICES				

Benefit Packages	Regions	Rate Category (Non-maternity)
Package A/B	North	Newborns
Package C	South	Preschoolers
	Central	Children
	Indiana Statewide	Adolescents
		Adult males
		Adult females

Category of Service (Non-maternity)

Inpatient Hospital

- Medical/Surgical/Non-Delivery Maternity
- Well Newborn
- Other Inpatient

Outpatient Hospital

- Emergency Room
- Other Outpatient

Pharmacy

- Prescription Drugs/OTC Drugs

Ancillaries

- Transportation
- DME, Home Health, Other Ancillary

Physician

- Inpatient and Outpatient Surgery
- Office Visits/Consults
- Well Baby Exams/Physical Exams
- Hospital Inpatient Visits
- Emergency Room Visits
- Radiology/Pathology
- Self Referral
- Other Professional

General Report Description	
SA-CRCS-2 Maternity Capitation Rate Calculation Sheet	
Purpose	Determine how the MCO's maternity utilization rates and costs per unit differ among categories of service and national benchmarks.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a semi-annual report. The MCO should submit cumulative year-to-date data each reporting period. The Capitation Rate Calculation Sheet (CRCS) report is based on those services with dates of service during the reporting period (i.e., the experience period) and for which the claims were paid, no later than 90 calendar days after the end of the reporting period (i.e., the lag period). The MCO must submit this report to the monitoring contractor and OMPP no later than 45 calendar days after the lag period (i.e., approximately 135 calendar days after the end of the experience period). Example 1, Reporting period #1 - Experience period (dates of service) – January 1st through June 30th; Lag period (claims paid for services incurred during experience period) – January 1st through September 30th; Report due date – November 15th. Example 2, Reporting period #2 - Experience period (dates of service) – January 1st through December 31st; Lag period (claims paid for services incurred during experience period) – January 1st (reporting year) through March 31st (next year); Report due date – May 15th. The MCO must submit a separate Excel file for each package (i.e., A, B and C) for each region and statewide. OMPP is providing a specific template for each combination and named for that combination. The matrix below provides the alpha indicators that OMPP has used in naming the files. (Continued on the next page.)

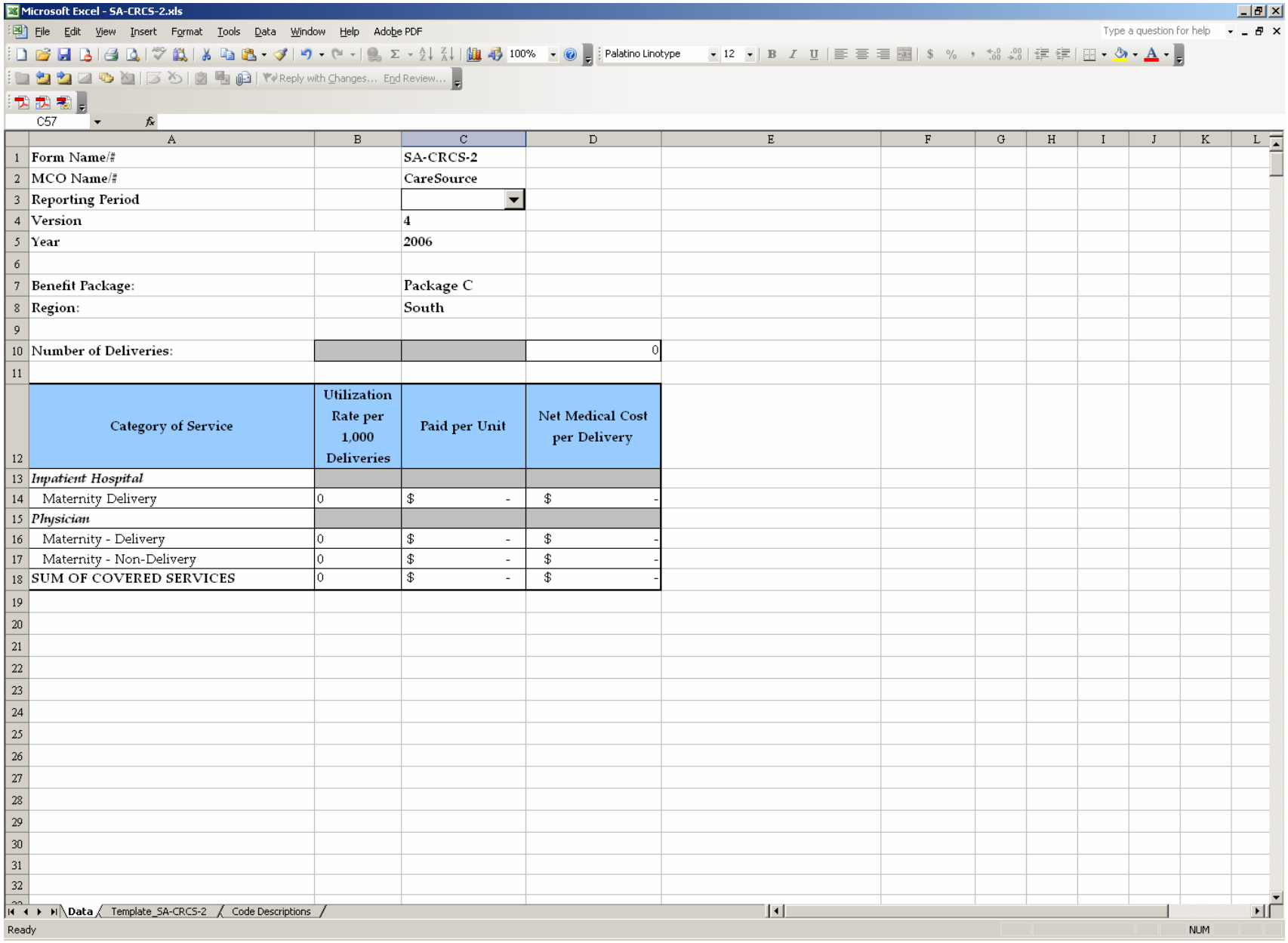
Comments/ Recommendations (Continued)	(Continued from the previous page.) Benefit Package Categories AB=Packages A and B C=Package C Region Categories N=North Region C=Central Region S=South Region I=Indiana Statewide For example: SA-CRCS-2-ABN.xls would be the file name for CRCS data for Benefit Package A/B, North Region and SA-CRCS-2-CC.xls would be the file name for CRCS data for Benefit Package C, Central Region.
Performance Measures	OMPP has not indicated specific performance measures at this time.
SA-CRCS-2 Data Elements	
1. Reporting (Experience) Period	
Qualifications/ Definitions	Indicate the calendar year and the last day of the reporting period for the year-to-date results, based on the experience date, i.e., date of service.
Formula	Select the calendar year and reporting (experience) period end date from the menu.
2. Benefit Package	
Qualifications/ Definitions	Select the template for a specific benefit package and region to which the data applies. The MCO must submit a separate Excel sheet for each package by each region. Benefit Packages Package A/B (Temporary Assistance for Needy Families, Children's Health Insurance Program-Phase I and pregnant women) Package C (Children's Health Insurance Program-Phase II)
Formula	Select the specific template for the benefit package combination.

3. Region	
Qualifications/ Definitions	Select the template for a specific region and benefit package to which the data applies. The MCO must submit a separate Excel sheet for each region by each benefit package. <u>Regions</u> North Central South Indiana Statewide
Formula	Select the specific template for the region combination.
4. Number of Deliveries	
Qualifications/ Definitions	Identify the total number of deliveries reported year-to-date based on inpatient hospital admissions (i.e., UB-92 claim forms).
Formula	Enter total cumulative year-to-date numbers.
5. Category of Service	
Qualifications/ Definitions	The sum of covered services for the category of service by benefit package by region as described in Table SA-CRCS-2: Maternity Categories of Service and Procedures Codes Ranges (attached).
Formula	Enter data per service category.
6. Utilization Rate per 1,000 Deliveries	
Qualifications/ Definitions	Identify the reported utilization rate per 1,000 deliveries for each category of service by benefit package and region selected.
Formula	Enter the total number for each service category and total all numbers in the row titled "Sum of Covered Services:" (Total number of units year-to-date/Number of deliveries year-to-date) x 1,000

7. Paid per Unit	
Qualifications/ Definitions	Identify the total net dollars paid amounts for each unit of service for each category of service by benefit package and region selected. (For inpatient hospital, the unit is one day.)
Formula	Enter the total amount paid for each service category and total all numbers in the row titled "Sum of Covered Services:" Total net cost/Total number of units
8. Net Medical Cost per Delivery	
Qualifications/ Definitions	Identify the service cost (i.e., net medical cost) per member per month per delivery for each category of service by benefit package and region selected.
Formula	Enter the total cost for each service category and total all numbers in the row titled "Sum of Covered Services:" ([Utilization rate per 1,000 deliveries] x [Cost per unit])/1,000

TABLE SA-CRCS-2: Maternity Categories of Service and Procedure Code Ranges

Type of Service	AP-DRGs/CPT – 4 Code	Medicare DRGs
Inpatient Maternity Delivery	0370	0370
	0371	0371
	0372	0372
	0373	0373
	0374	0374
	0375	0375
	0650	
	0651	
	0652	
Physician		
Maternity – Delivery	59400	Excludes anesthesiologist services.
	59409	
	59410	
	59510	
	59514	
	59515	
	59610 – 59622	
Maternity – Non-Delivery	59320	Excludes anesthesiologist services.
	59325	
	59412	
	59425	
	59426	
	59428	
	59430	
	59899	



Microsoft Excel - SA-CRCS-2.xls

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4	Version		4	
5	Year		2006	
6				
7	Benefit Package:		Package C	
8	Region:		South	
9				
10	Number of Deliveries:			0
11				
12	Category of Service	Utilization Rate per 1,000 Deliveries	Paid per Unit	Net Medical Cost per Delivery
13	*Inpatient Hospital*			
14	Maternity Delivery	0	$ -	$ -
15	*Physician*			
16	Maternity - Delivery	0	$ -	$ -
17	Maternity - Non-Delivery	0	$ -	$ -
18	SUM OF COVERED SERVICES	0	$ -	$ -

MCO Name_____ MCO name will be on the template.

Reporting Period_____ Select the reporting (experience) period range from the menu.

Benefit Package:_____ The benefit package will be identified on the template.

Region:_____ The region will be identified on the template.

Number of Deliveries:_____ Insert the number of deliveries that have occurred cumulative year-to-date for the reporting period.

For inpatient hospital, the unit is one day.

Category of Service	Utilization Rate per 1,000 Deliveries	Paid per Unit	Net Medical Cost per Delivery
Inpatient Hospital			
Maternity Delivery	Admits/Days		
Physician			
Maternity - Delivery	Services		
Maternity - Non-Delivery	Services		
SUM OF COVERED SERVICES			

Benefit Packages	Regions	Category of Service (Maternity)
Package A/B	North	**Inpatient Hospital**
Package C	South	Maternity Delivery
	Central	**Physician**
	Indiana Statewide	Maternity - Delivery
		Maternity - Non-Delivery

General Report Description	
QR-F1 Indicators of Financial Stability	
Purpose	Identify financial trends and determine the MCO's financial stability and ability to continue to administer health care delivery to its members.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a quarterly report. The MCO must submit the report to the monitoring contractor and OMPP by 45 calendar days after the last day of the reporting calendar quarter, except for the fourth quarter reports, which are due March 1st of each year. Financial indicators reported as 'corporate' in this report refer only to the MCO's business in the State of Indiana. For each indicator, as applicable, use statutory accounting principles adopted by the National Association of Insurance Commissioners (NAIC) and used by the Indiana Department of Insurance (IDOI), Bulletin #102. The MCO can find additional information on the IDOI requirements on the IDOI website at: http://www.in.gov/idoi/companyinfo/AnnualFilings.html
Performance Measures	OMPP will monitor the MCO's financial performance using the following indicators:[1] Medical Loss Ratio: Between 82 percent and 88 percent Administrative Expense Ratio: Between nine percent and 13 percent Profit Margin Ratio: Less than four percent Average Number of Days of Unpaid Claims Ratio: Less than 60 calendar days Percentage of Risk Transfer (Capitated) Business: Less than 50 percent

[1] McCue, Michael J., Hurley, Robert E., Chukmaitov, Askar., "Financial Performance Indicators for Health Plans in Medicaid Managed Care;" Managed Care Quarterly 2004; Volume12 (1): pages 16-22
"Wall Street's View of Managed Care;" Health Care Industry Market Update; Centers For Medicare and Medicaid Services; March 24, 2003

QR-F1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the calendar year and reporting quarter for which the MCO is reporting financial indicator information.
Formula	Select the reporting quarter from the menu.
2. Total Membership	
Qualifications/ Definitions	Indicate the total number of members enrolled as of the last day of the quarter and year-to-date for the MCO's Indiana (corporate) membership, including all commercial, Medicare and Medicaid (inclusive of Hoosier Healthwise) members.
Formula	Enter the total number of corporate members enrolled as of the last day of the reporting quarter and year-to-date.
3. Total Revenues	
Qualifications/ Definitions	Indicate the total revenue generated from Hoosier Healthwise premiums for the quarter, and the total amount of all revenues received that are designated for the MCO's Hoosier Healthwise program, less investment income, for the quarter.
Formula	Sum the income generated from all sources during the quarter less investment income for the quarter. Enter in $000,000,000.00 format.
4. Net Income	
Qualifications/ Definitions	Indicate the total Hoosier Healthwise and Indiana (corporate) net income generated from all sources for the quarter and year-to-date.
Formula	Enter in $000,000,000.00 format.

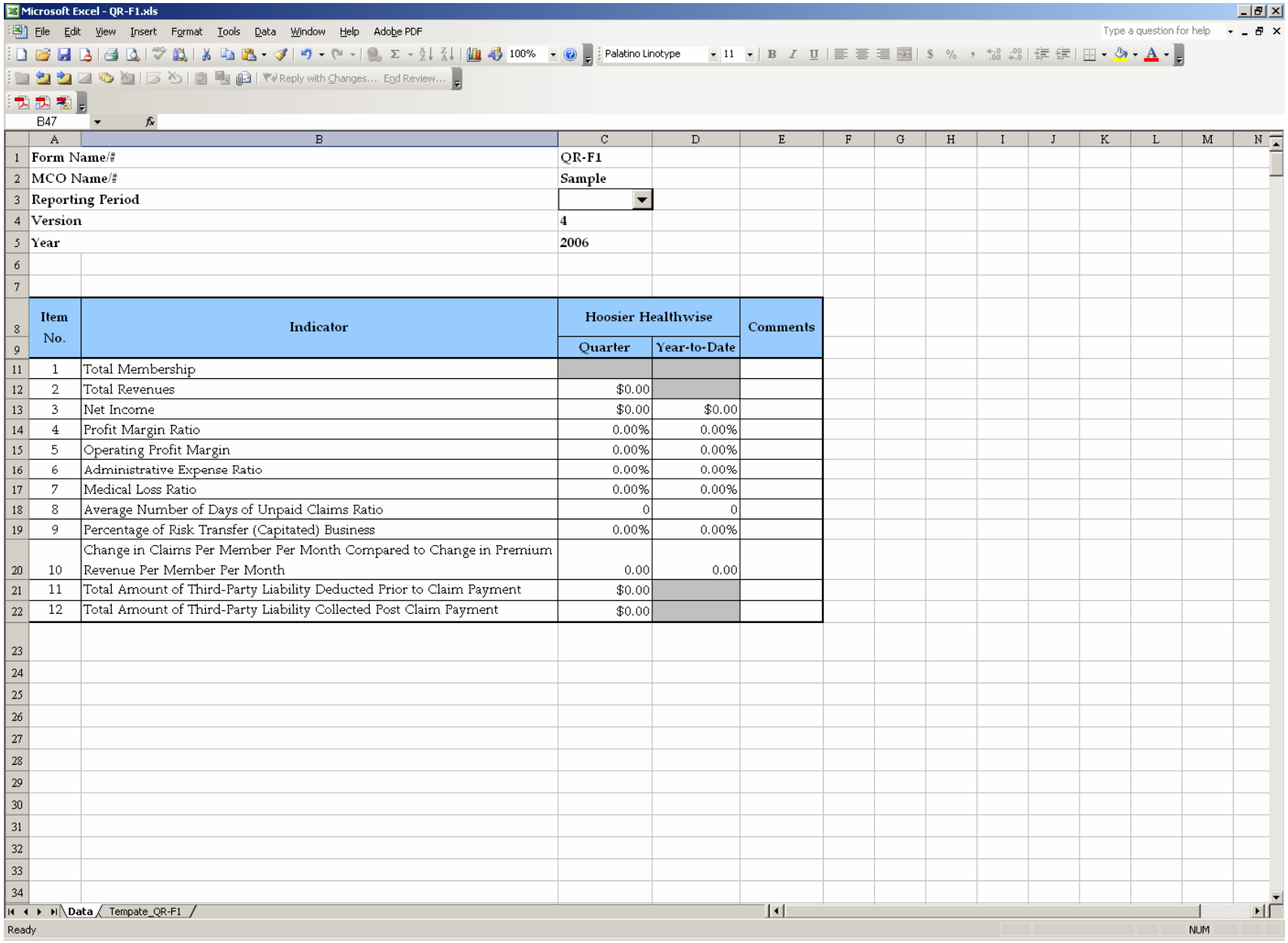
5. Profit Margin Ratio	
Qualifications/ Definitions	Indicate the profit margin specific to the Hoosier Healthwise program for the quarter and year-to-date. OMPP's performance measure for this indicator is less than four percent. As one of the more critical measurement ratios, this ratio measures the efficiency of management. It is an indicator of the percentage of each revenue dollar that is ultimately realized into net income. The comparison of the net profit margin to prior periods and industry statistics reveal operating efficiency and how successful management is in product pricing.
Formula	Calculate Hoosier Healthwise quarterly and year-to-date profit margin ratio by dividing net income (loss) by total revenues, including all income from premium revenues (i.e., capitation and case rate maternity payments from OMPP), investments and non-health care-related revenue. Enter data as a percent (e.g., 3.00 percent). If results are a fraction of one percent, enter as "0.00" (e.g., 0.03 percent). Profit Margin Ratio = [Net Income (Loss)/Total Revenues] x 100
6. Operating Profit Margin	
Qualifications/ Definitions	Indicate the operating profit margin specific to the Hoosier Healthwise program for the quarter and year-to-date. Operating profit margins are the ratio of medical and hospital expenses to premium revenues (i.e., capitation and case rate maternity payments from OMPP).
Formula	Calculate Hoosier Healthwise quarterly and year-to-date operating profit margin by dividing medical and hospital expenses by premium revenues and subtracting the resulting amount from one. Enter data as a percent (e.g., 3.00 percent). If results are a fraction of one percent, enter as "0.00" (e.g., 0.03 percent). Operating Profit Margin = [1 – (Medical and Hospital Expenses/Premium Revenues)] x 100

7. Administrative Expense Ratio	
Qualifications/ Definitions	Indicate the percentage of total premium revenue (i.e., capitation and case rate maternity payments from OMPP) that covers administrative expenses for the quarter and year-to-date specific to the Hoosier Healthwise program. OMPP's performance measure for this indicator is between 9 to 13 percent. This ratio measures the MCO's administrative expenses. It is an indicator of how much of the premium of the company is expended on general expenses, and how efficient the company is in its operations. Yields outside the expected range may indicate a need for greater cost control by management.
Formula	Calculate Hoosier Healthwise quarterly and year-to-date administrative expense ratio as follows. Enter data as a percent (e.g., 3.00 percent). If results are a fraction of one percent, enter as "0.00" (e.g., 0.03 percent). Administrative Expense Ratio = [(A)/(B)] x 100 A. Total administration expenses B. Premium revenues (i.e., capitation and case rate maternity payments from OMPP)
8. Medical Loss Ratio	
Qualifications/ Definitions	Indicate the percentage of premium revenue (i.e., capitation and case rate maternity payments from OMPP) that covers medical and hospital expenses for the quarter and year-to-date specific to the Hoosier Healthwise program. OMPP's performance measure for this indicator is between 82 and 88 percent. This ratio measures an important element of a company's profitability. It is an indicator of underwriting effectiveness, premium sufficiency, favorable claims experience and changes to the claims adjudication process.
Formula	Calculate Hoosier Healthwise quarterly and year-to-date medical loss ratio as follows. Enter data as a percent (e.g., 3.00 percent). If results are a fraction of one percent, enter as "0.00" (e.g., 0.03 percent). Medical Loss Ratio = [(A)/(B)] x 100 A. Total medical and hospital expenses B. Premium revenues

9. Average Number of Days of Unpaid Claims Ratio	
Qualifications/ Definitions	Indicate the Hoosier Healthwise average number of calendar days of unpaid claims for the quarter and year-to-date. OMPP's performance measure for this indicator is less than 60 calendar days. This ratio measures the average number of days of reported unpaid claims in inventory by reducing annual incurred claims to a daily average. A result outside the expected range may indicate a problem with claims administration, cash flow, or a provider lag.
Formula	Calculate Hoosier Healthwise quarterly and year-to-date average number of days of unpaid claims ratio as follows and enter data as a whole number to two decimal points (e.g., 00.00). Average Number of Days of Unpaid Claims Ratio = A/[(B – C)/D)] A. Reported claims payable (excludes unreported claims) B. Medical and hospital expenses paid C. Capitation payments paid D. Number of days in reporting period
10. Percentage of Risk Transfer (Capitated) Business	
Qualifications/ Definitions	Insert percent of risk transfer (capitated) business specific to the Hoosier Healthwise program for the quarter and year-to-date. OMPP's performance measure for this indicator is less than 50 percent. This ratio recognizes the increased use of capitation to transfer hospital and medical risk outside the licensed entity to unregulated intermediaries or significant providers. It measures the extent to which a company has direct control over the underwriting results of its policies and is a possible indicator of financial problems outside the results reported by the company, but related to the benefits that it is obligated to provide or indemnify.
Formula	Calculate Hoosier Healthwise quarterly and year-to-date percentage of risk transfer (capitated) business as follows and enter data as a percent. If results are a fraction of one percent, enter as "0.00". Quarterly Percentage of Risk Transfer (Capitated) Business = [(A)/(B)] x 100 A. Capitation payments paid B. Total medical and hospital expenses

11. Change in Claims Per Member Per Month Compared to Change in Premium Revenue Per Member Per Month	
Qualifications/ Definitions	Indicate the corporate and Hoosier Healthwise change in claims per member per month compared to the change in premium revenue (i.e., capitation and case rate maternity payments from OMPP) per member per month for the quarter and year-to-date. This ratio was developed as a measure of overall rating and rate adequacy. It is one of the accompanying inter-dependent series of ratios that test financial strength. As an individual overall ratio, a result outside the expected range may require a deeper review as to the cause. New lines of business; changes in existing lines of business; changes in reserving methods; shift in definition of claims versus claims adjustment expenses; and significant gains or losses in enrollment can affect the result.
Formula	Calculate the change in claims per member per month compared to change in premium revenue (i.e., capitation and case rate maternity payments from OMPP) per member per month as follows and enter data rounded to two decimal points (e.g., 00.00). Change in Claims Per Member Per Month Compared to Change in Premium Revenue Per Member Per Month = E - J A. Total medical and hospital expenses for the current reporting period B. Member months for the current reporting period C. Total medical and hospital expenses for the prior reporting period D. Member months for the prior reporting period E. (A/B)/(C/D) F. Premium revenue for the current reporting period G. Member months for the current reporting period H. Premium revenue for the prior reporting period I. Member months for the prior reporting period J. (F/G)/(H/I)

12. Total Amount of Third-Party Liability Deducted Prior to Claim Payment	
Qualifications/ Definitions	Indicate the total amount of third-party liability deducted prior to claim payment during the quarter as of the last day of the reporting period (Hoosier Healthwise only). Third-party liability deductions are money deducted from the "paid amount" on the claim because the MCO determined that amount to be covered by the third-party insurer prior to the MCO's payment of the claim.
Formula	Enter in $000,000,000.00 format.
13. Total Amount of Third-Party Liability Collected Post Claim Payment	
Qualifications/ Definitions	Indicate the total amount of third-party liability collections post claim payment accumulated during the quarter as of the last day of the reporting period (Hoosier Healthwise only). Third-party liability collections are money collected from any third-party insurer for any health care expenses for services delivered to a member previously paid for by the MCO that have been determined to be covered by the third-party insurer. The MCO must report the amounts collected but does not have to return the amounts to OMPP.
Formula	Enter in $000,000,000.00 format.
14. Comments	
Qualifications/ Definitions	Indicate any comments the MCO has regarding the specific financial indicator listed.
Formula	Limit comments to 200 alpha/numeric characters per financial indicator.



Form Name/#	QR-F1	
MCO Name/#	Sample	
Reporting Period		
Version	4	
Year	2006	

Item No.	Indicator	Hoosier Healthwise		Comments
		Quarter	Year-to-Date	
1	Total Membership			
2	Total Revenues	$0.00		
3	Net Income	$0.00	$0.00	
4	Profit Margin Ratio	0.00%	0.00%	
5	Operating Profit Margin	0.00%	0.00%	
6	Administrative Expense Ratio	0.00%	0.00%	
7	Medical Loss Ratio	0.00%	0.00%	
8	Average Number of Days of Unpaid Claims Ratio	0	0	
9	Percentage of Risk Transfer (Capitated) Business	0.00%	0.00%	
10	Change in Claims Per Member Per Month Compared to Change in Premium Revenue Per Member Per Month	0.00	0.00	
11	Total Amount of Third-Party Liability Deducted Prior to Claim Payment	$0.00		
12	Total Amount of Third-Party Liability Collected Post Claim Payment	$0.00		

MCO name will be on the template.

MCO Name_____

Reporting Period_____

Select the reporting quarter from the menu.

For each indicator, as applicable, use statutory accounting principles adopted by the National Association of Insurance Commissioners (NAIC) and used by the Indiana Department of Insurance (IDOI), Bulletin #102.

Item No.	Indicator	Hoosier Healthwise		Comments
		Quarter	Year-to-Date	
1	Total Membership			
2	Total Revenues			
3	Net Income			
4	Profit Margin Ratio*			
5	Operating Profit Margin*			
6	Administrative Expense Ratio*			
7	Medical Loss Ratio*			
8	Average Number of Days of Unpaid Claims Ratio*			
9	Percentage of Risk Transfer (Capitated) Business*			
10	Change in Claims Per Member Per Month Compared to Change in Premium Revenue Per Member Per Month			
11	Total Amount of Third-Party Liability Deducted Prior to Claim Payment			
12	Total Amount of Third-Party Liability Collected Post Claim Payment			

Enter the total revenues received in this reporting quarter in $000,000,000.00 format.

Enter the net income as of the end of the reporting quarter in $000,000,000.00 format.

Insert the appropriate Hoosier Healthwise-specific indicator for the quarter and year-to-date; MCO does not enter data into shaded cells. All data should be in appropriate format and rounded to two decimal points.

Indicate any comments regarding the specific financial indicator; limit comments to 200 alpha/numeric characters.

Enter the amount of third-party deducted after claim payment during the reporting quarter in $000,000,000.00 format.

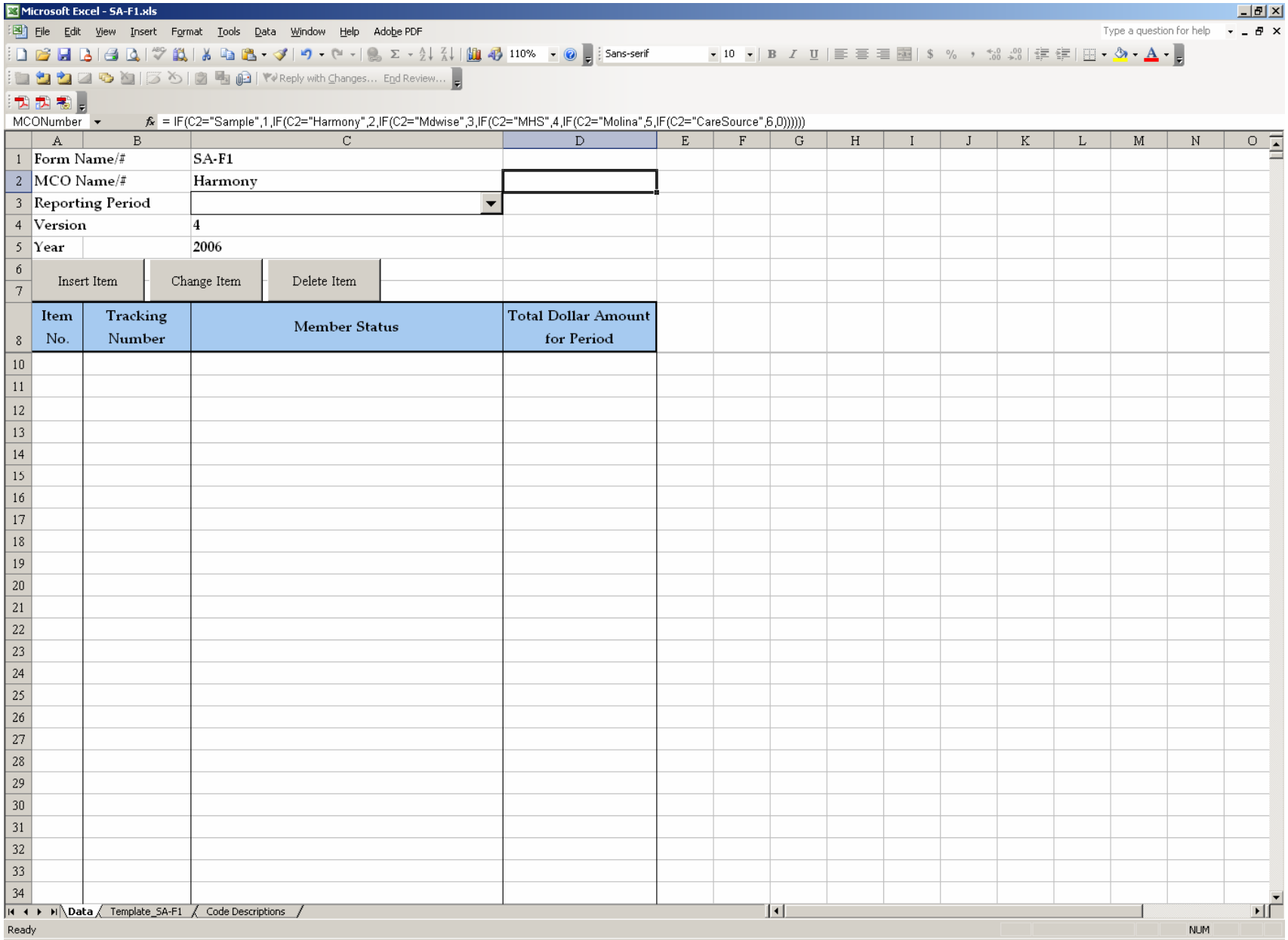
Enter the third-party liability collections collected post claim payment during the reporting quarter in $000,000,000.00 format.

* All data must be expressed in the appropriate format and rounded to two decimal points, e.g., 10.05.

General Report Description	
QR-IDOI Indiana Department of Insurance (IDOI) Filing	
Purpose	Monitor the MCO's financial solvency and confirm the MCO's financial ability to administer health care service delivery to its members.
Required Submission Type	Electronic submission per the IDOI required format.
Comments/ Recommendations	This is a quarterly report. The MCO must submit copies of its quarterly and annual IDOI filings to the monitoring contractor and OMPP no later than 45 calendar days after the end of the calendar quarter except for the fourth quarter (i.e., annual) report, which is due by March 1st each year. If the MCO submits an IDOI filing which encompasses financial information for its corporate entity that includes data other that Hoosier Healthwise-specific financials, the MCO must submit a supplemental Balance Sheet and Statement of Revenues and Expenses in an electronic format specifically for the Hoosier Healthwise program (i.e., exclusive of financial information for any other lines of business) to the monitoring contractor and OMPP with its IDOI filing. For additional information about this reporting requirement and detailed filing instructions, the MCO can review the IDOI website at: http://www.in.gov/idoi/companyinfo/AnnualFilings.html, "Annual Filing Forms for Insurance Companies" under "Health Maintenance Organizations/ Limited Service Health Maintenance Organizations".
Performance Measures	The MCO must meet and maintain the solvency standards established by the State.
QR-IDOI Data Elements	
1. All Data Elements	
Qualifications/ Definitions	Insert required data per the IDOI filings using the National Association of Insurance Commissioners (NAIC) format.
Formula	IDOI filing requirements.

General Report Description	
SA-F1 Stop Loss	
Purpose	Monitor MCO financial stability by reviewing the number of members with health care claims costs exceeding the stop loss amount and the total dollar amounts exceeding the stop loss.
Required Submission Type	Excel template for database analysis.
Comments/ Recommendations	This is a semi-annual report. The MCO must submit this report to the monitoring contractor and OMPP no later than one month and 15 days after the lag period (i.e., approximately 135 calendar days after the end of the six-month experience period.) Once the MCO has reported a member on the stop loss report, the member must be listed in subsequent stop loss reports for the remainder of the reporting calendar year.
Performance Measures	The MCO must have stop loss coverage for members accumulating more than $125,000 in claims costs during a calendar year.
SA-F1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the semi-annual reporting period for which the MCO is submitting stop loss.
Formula	Select the semi-annual reporting period from the menu.
2. Item No.	
Qualifications/ Definitions	Consecutive number for all members listed on the report.
Formula	The field auto-fills with the consecutive number after user completes other data fields.

3. Tracking Number	
Qualifications/ Definitions	Provide a unique number for tracking each member who has exceeded the $125,000 stop loss threshold during the reporting calendar year. This tracking number may be the member's RID number. Use the same unique tracking number every time that specific member is listed on subsequent stop loss reports. The member-specific tracking number can be any alpha/numeric code that the MCO assigns to the member for the purposes of reporting stop loss.
Formula	MCO may determine any alpha / numeric combination limited to 25 alpha/ numeric characters.
4. Member Enrollment Status	
Qualifications/ Definitions	Indicate the enrollment status of the member as of the last day of the reporting period from the following options: <u>Member Enrollment Status</u> Enrolled, claims incurred this quarter Enrolled, no claims incurred this quarter Not enrolled as of the last day of the quarter Other, identify
Formula	Select the member enrollment status from the menu; if "Other, identify", limit status description to 50 alpha/numeric characters.
5. Total Dollar Amount Year-to-Date	
Qualifications/ Definitions	For each member listed who has accumulated claims costs over $125,000 during the calendar year, enter the total claims costs accumulated year-to-date in the reporting period.
Formula	Enter the total year-to-date dollar amount over $125,000 in $000,000,000 format.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File Edit View Insert Format Tools Data Window Help Adobe PDF
Type a question for help
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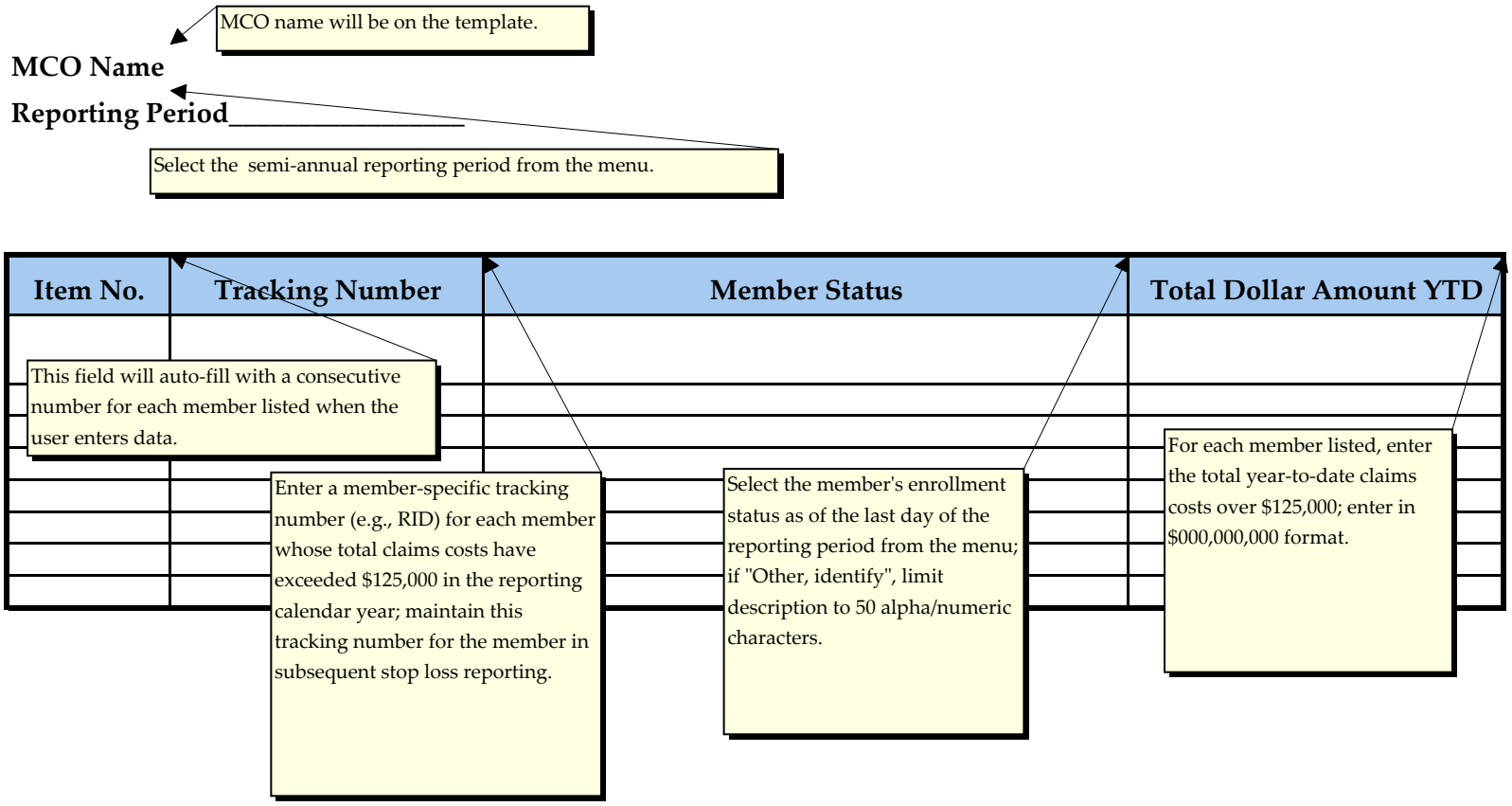
110%
Reply with Changes... End Review...
MCONumber
= IF(C2="Sample",1,IF(C2="Harmony",2,IF(C2="Mdwise",3,IF(C2="MHS",4,IF(C2="Molina",5,IF(C2="CareSource",6,0))))))
Form Name/#
SA-F1
MCO Name/#
Harmony
Reporting Period
Version
4
Year
2006
Insert Item
Change Item
Delete Item
Item No.
Tracking Number
Member Status
Total Dollar Amount for Period
Data
Template_SA-F1
Code Descriptions
Ready
NUM


MCO name will be on the template.
MCO Name
Reporting Period_____
Select the semi-annual reporting period from the menu.
Item No.
Tracking Number
Member Status
Total Dollar Amount YTD
This field will auto-fill with a consecutive number for each member listed when the user enters data.
Enter a member-specific tracking number (e.g., RID) for each member whose total claims costs have exceeded $125,000 in the reporting calendar year; maintain this tracking number for the member in subsequent stop loss reporting.
Select the member's enrollment status as of the last day of the reporting period from the menu; if "Other, identify", limit description to 50 alpha/numeric characters.
For each member listed, enter the total year-to-date claims costs over $125,000; enter in $000,000,000 format.

Member Status
Enrolled, claims incurred this quarter
Enrolled, no claims incurred this quarter
Not enrolled during the reporting quarter
Other, identify

General Report Description	
AN-PIP Physician Incentive Plan	
Purpose	Identify and describe the MCO's provider incentive agreements between various contractual relationships.
Required Submission Type	The MCO should provide the worksheets and forms required by the Centers for Medicare and Medicaid Services (CMS).
Comments/ Recommendations	This is an annual report. The MCO must prepare the CMS worksheets and forms for OMPP's review during on-site monitoring by January 31st for those financial arrangements that are in place at the start of the contact and each reporting calendar year (i.e., January 1st). CMS considers the MCO as the first party in the relationship and considers the "Provider" as the second party of the contractual relationship. The MCO must correctly represent the hierarchy of contracting and subcontracting relationships. For example, if the MCO selects the "MCO to physician group" relationship, it should aggregate all physician groups it contracts with that have substantially the same incentive agreements and stop-loss requirements. In a separate row, the MCO should select "Physician group to physician" to enter the physician group-physician arrangements only for the physicians associated with those provider groups. The CMS Provider Data Worksheet and all forms and instructions are available at: http://www.cms.hhs.gov/healthplans/pip/disclose.asp.
Performance Measures	OMPP has not indicated specific performance measures at this time.

General Report Description	
AN-F1 Insurance Premium Notice	
Purpose	Monitor insurance premium renewals annually.
Required Submission Type	Excel template.
Comments/ Recommendations	This is an on-going annual report. The MCO must provide the requested information throughout the year to OMPP during on-site monitoring visits. The Excel template is provided for the MCO's convenience; however, OMPP will maintain this information. MCO must obtain insurance and submit new policies or premium renewal notices to OMPP.
Performance Measures	The MCO must submit for OMPP's review and approval no less than 30 calendar days before a replacement policy becomes effective or the previously approved policy's renewal is due: • The policy for re-insurance • The certificate of insurance coverage for other required insurance
AN-F1 Data Elements	
1. Reporting Period	
Qualifications/ Definitions	Indicate the calendar year for which the MCO's insurance information data applies.
Formula	Enter year in YYYY format.
2. Item No.	
Qualifications/ Definitions	Consecutively number the individual policies listed in the report.
Formula	Consecutively number each policy listed on the report beginning with number 1.

3. Type of Insurance	
Qualifications/ Definitions	Identify type of coverage offered under the insurance policy. The MCO must report on the following types of insurance and may add others: Professional Liability (Malpractice) Insurance for the MCO Professional Liability (Malpractice) Insurance for the Medical Director Workers' Compensation Insurance Comprehensive Liability Insurance Fidelity Bond or Fidelity Insurance Reinsurance Other, identify
Formula	If MCO enters "Other, identify", limit type description to 100 alpha/numeric characters.
4. Insurance Company Name	
Qualifications/ Definitions	Identify the insurance company holding the coverage as written on the policy.
Formula	Enter name and limit name to 100 alpha/numeric characters.
5. Coverage Amount(s)	
Qualifications/ Definitions	Identify the amount of coverage (e.g., dollar amount per occurrence or annual maximums or per member/person amounts) for each insurance policy listed.
Formula	Enter dollar amounts and indicate the coverage type.
6. Policy Effective Date	
Qualifications/ Definitions	Indicate the date the insurance policy certificate of coverage became effective.
Formula	Enter in MM/DD/YY format.
7. Policy End Date	
Qualifications/ Definitions	Indicate the date the insurance policy certificate of coverage will end if not renewed.
Formula	Enter in MM/DD/YY format.

8. Premium Renewal Notice Date	
Qualifications/ Definitions	Indicate the date the insurance policy certificate of coverage renewal must be submitted to OMPP for approval; this date should be at least 30 calendar days before the "Premium End Date."
Formula	Enter in MM/DD/YY format.
9. OMPP Approval Date	
Qualifications/ Definitions	Indicate the date the MCO received OMPP's approval of the certificate of coverage renewal.
Formula	Enter in MM/DD/YY format.
10. Comments	
Qualifications/ Definitions	Indicate any narrative comments that the MCO deems appropriate related to the MCO's insurance policies.
Formula	Limit comments to 200 alpha/numeric characters.

MCO Name: _____

Reporting Period: _____

Enter MCO's name.

Indicate calendar year in YYYY format.

Types of insurance listed are required; MCO may add others.

Enter name as written on policy; limit name to 100 alpha/numeric characters.

Item No.	Type of Insurance	Insurance Company Name	Coverage Amount	Policy Effective Date	Policy End Date	Premium Renewal Notice Date	OMPP Approval Date	Comments
1	Professional Liability (Malpractice) Insurance for the MCO							
2	Professional Liability (Malpractice) Insurance for the Medical Director							
3	Workers' Compensation Insurance							
4	Comprehensive Liability Insurance							
5	Fidelity Bond or Fidelity Insurance							
6	Reinsurance							
7	Other, identify							

Enter the dollar amount and indicate the type of coverage (e.g., per occurrence, per member/person, annual maximum, etc.).

Enter date policy will end without renewal in MM/DD/YY format.

Insert any comments regarding insurance policies the MCO deems necessary; limit comments to 200 alpha/numeric characters.

Enter date policy became effective in MM/DD/YY format.

Enter date MCO must notify OMPP of renewal in MM/DD/YY format.

Enter date MCO received OMPP approval in MM/DD/YY format.

If "Other, identify", limit policy type to 100 alpha/numeric characters and list each policy separately.

General Report Description	
AN-FQHC Reimbursement for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) Services	
Purpose	Identify payments and performance incentives to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to identify any supplemental payments that may be required of the State to the FQHC or RHC to ensure that the FQHC or RHC receives reimbursement for the services rendered to the MCO's members equal to the amount the provider is entitled under the Benefits Improvement and Protection Act of 2000 (BIPA).
Required Submission Type	Excel template.
Comments/ Recommendations	This financial report is for two different reporting periods. The MCO must submit parts A and B of this report to the monitoring contractor and OMPP no later than 45 calendar days after the end of the second quarter. OMPP is providing an Excel workbook with 10 worksheet templates. Each part must include a summary worksheet and worksheets for each Benefit Package (i.e., Package A/B and C) and for fee-for-service claims and claim level encounter data for which the provider has been paid a capitation. The MCO should submit separate Excel workbooks for each FQHC/RHC provider as follows: A) Information on claims for services incurred (i.e., dates of service) during the previous calendar year (i.e., January through December), and adjudicated as "paid" by June 30th of the current year, for all FQHC providers; and, B) Information on claims for services incurred (i.e., dates of service) during the first six months of the current calendar year (i.e., January through June) and adjudicated as "paid" by July 30th for all FQHC providers. The MCO may rename the excel files to differentiate one provider's Excel workbook template file from another provider's file by including an abbreviated provider name in the file name, e.g., AN-FQHC_Goodline.xls would be a workbook template file for the Goodline Clinic. (Continued on the next page.)

Comments/ Recommendations (Continued)	(Continued from the previous page.) For each part (i.e., A and B) and for each benefit package (i.e., Package A/B and Package C), the MCO must also report: • Total dollars paid for fee-for-service claims • Total dollars paid for quality incentives • Total dollars paid as capitation payments • Total dollars paid as administration fees OMPP reserves the right to audit the data submitted in this report.
Performance Measures	OMPP has not indicated specific performance measures at this time.
AN-FQHC Data Elements	
1. FQHC/RHC Provider Name	
Qualifications/ Definitions	Indicate the name of the FQHC or RHC on which the MCO is reporting. (See Table FQHC below.)
Formula	Not applicable.
2. FQHC/RHC Provider Number	
Qualifications/ Definitions	Insert the FQHC/RHC Indiana Health Coverage Program's (IHCP) provider identification number for the FQHC or RHC provider identified in Item 1, "FQHC/RHC Provider Name." (See Tables FQHC-1, -2 and -3 below.)
Formula	Not applicable.
3. Contract or Non-Contract Provider	
Qualifications/ Definitions	Indicate if the MCO contracts with the provider identified in Item 1.
Formula	Enter "yes" or "no" as appropriate.

4. Beginning Incurred Date of Reporting Period	
Qualifications/ Definitions	Indicate the beginning date of the reporting period for which the MCO is submitting the report. Base the reporting period on the requested dates of services "incurred" period.
Formula	Enter in MM/DD/YYYY format.
5. Ending Incurred Date of Reporting Period	
Qualifications/ Definitions	Indicate the ending date of the reporting period for which the MCO is submitting the report. Base the reporting period on the requested dates of service "incurred" period.
Formula	Enter in MM/DD/YYYY format.
6. Paid Date Period	
Qualifications/ Definitions	Indicate the paid date period for the beginning and ending reporting period or lag period, as appropriate.
Formula	Enter in MM/DD/YYYY format.
7. Total Dollars Paid For Fee-For-Service Claims	
Qualifications/ Definitions	Identify the total dollar amount "paid" to the provider as fee-for-service claims during each month of the reporting period.
Formula	Enter dollar amount in $XXX,XXX format. If no fee-for-service claims are paid during the month, leave this field blank.
8. Total Dollars Paid For Quality Incentives	
Qualifications/ Definitions	Identify the total dollar amount paid for quality performance incentives during each month of the reporting period. This amount should not include dollars reimbursed for fee-for-service or capitated services.
Formula	Enter dollar amount in $XXX,XXX format. If no quality incentives are paid during the month, leave this field blank.

9. Total Dollars Paid As Capitation Payments	
Qualifications/ Definitions	Indicate the monthly capitation payments from the MCO to the FQHC/RHC during the reporting period. This number should not include any quality incentives paid during each month of the reporting period or any amount paid as fee-for-service.
Formula	Enter dollar amount in $XXX,XXX format. If no capitation payments were made or if the MCO's reimbursement arrangement to the FQHC/RHC does not include capitation, leave this field blank.
10. Total Dollars Paid As Administrative Fees	
Qualifications/ Definitions	Indicate the monthly administrative fees paid from the MCO to the FQHC/ RHC during the reporting period.
Formula	Enter dollar amount in $XXX,XXX format. If no administrative fees were paid or if the MCO's reimbursement arrangement to the FQHC/RHC does not include administrative fees, leave this field blank.
11. Item No.	
Qualifications/ Definitions	Consecutively number each member item for the report.
Formula	Enter a consecutive number beginning with number 1.
12. Member First Name	
Qualifications/ Definitions	Indicate the member's first name as listed on the referenced claim item.
Formula	Not applicable.
13. Member Last Name	
Qualifications/ Definitions	Indicate the member's last name as listed on the referenced claim item.
Formula	Not applicable.
14. Recipient Identification Number	
Qualifications/ Definitions	Insert the member's Medicaid recipient identification number (RID) that is associated with the reported claim.
Formula	Enter member's RID.

15. Claim Number	
Qualifications/ Definitions	Identify the claim number being submitted for the report.
Formula	Enter number exactly as listed on the MCO's claims system.
16. Claim Number Detail Line	
Qualifications/ Definitions	Insert the numeric detail line number of the claim.
Formula	Not applicable.
17. Date of Service	
Qualifications/ Definitions	Indicate the date the identified member received the service that is being reported on the claim.
Formula	Enter in MM/DD/YYYY format.
18. Date Paid	
Qualifications/ Definitions	Indicate the date the submitted claim was adjudicated as "paid" by the MCO to the FQHC or RHC.
Formula	Enter in MM/DD/YYYY format.
19. EX1, EX2, EX3	
Qualifications/ Definitions	Explain any benefits (i.e., Explanation of Benefits) using the additional columns as necessary to identify more than one benefit.
Formula	Limit explanation to 200 alpha/numeric characters.
20. Billed Amount	
Qualifications/ Definitions	Indicate the billed amount of the detail line number of the claim.
Formula	Enter in $XXX,XXX format.

21. Paid Amount	
Qualifications/ Definitions	Indicate the paid amount of the detail line number of the claim.
Formula	Enter in $XXX,XXX format.
22. Place of Service Code	
Qualifications/ Definitions	Insert the place of service numeric code as appropriate: <u>Place of Service Codes</u> 11 Ambulance 24 Ambulatory Surgical Center 25 Birthing Center 23 Emergency Room-Hospital 50 Federally Qualified Health Center 12 Home 21 Inpatient Hospital 81 Laboratory 32 Nursing Facility 11 Office 99 Other, identify 22 Outpatient Hospital 61 Rehabilitation Facility-Inpatient 62 Rehabilitation Facility-Outpatient 72 Rural Health Clinic 31 Skilled Nursing Facility 20 Urgent Care Facility
Formula	Enter appropriate numeric code; if "Other, identify", limit description to 25 alpha/numeric characters.
23. Procedure Code	
Qualifications/ Definitions	Insert the procedure code as listed for the detail line number on the claim.
Formula	Enter procedure code.

24. Diagnosis Codes	
Qualifications/ Definitions	Insert the primary diagnosis code for the detail line number of the claim using additional columns as necessary for secondary diagnosis codes as listed on the claim.
Formula	Enter diagnosis codes.
25. Provider First Name	
Qualifications/ Definitions	Identify the first name of the rendering provider as listed on the claim.
Formula	Not applicable.
26. Provider Last Name	
Qualifications/ Definitions	Identify the last name of the provider as listed on the claims.
Formula	Not applicable.
27. Provider Number	
Qualifications/ Definitions	Enter the IHCP provider number for the rendering provider.
Formula	Enter IHCP provider number.

TABLE FQHC-1: List of FQHC Providers

Name	Provider Number(s)
Citizens Health Corporation	100196020
East Chicago Community Health Clinic	200118670
Echo Community Health Clinic	200079040
Edinburgh/Trafalgar Family Health Center	200127470
HealthNet	100117700
	200013620
Heart City Health Center	100097610
Hilltop Community Health Center	200317310
Indiana Health Centers	100071250
Madison County Community Health Center	200271310
Neighborhood Health Clinic	100050750
North Shore Community Health Center	200331170
Open Door BMH/Health Center	200167970
Raphael Health Center	200077460
Shalom Health Care Center	200392480
Tippecanoe Community Health Clinic	100232630

TABLE FQHC-2: List of RHC Providers, Provider-based

Name	Medicaid Number	Hospital
Jennings Family Care	100195140A	St. Vincent Jennings Hospital
Family Health Center of Winchester	200292060D	St. Vincent Randolph Hospital
Family & Occupational Medicine Center-Ridgeville	200292060C	St. Vincent Randolph Hospital
Family Health Center of Union City	200292060B	St. Vincent Randolph Hospital
Family & Occupational Medicine Center-Lynn	200292060A	St. Vincent Randolph Hospital
St. Vincent North Clinic	200307100A	St. Vincent Williamsport Hospital
St. Vincent South Clinic	200307100B	St. Vincent Williamsport Hospital
Royal Center Family Practice	200003920D	Memorial Hospital of Logansport
Knightstown Family Health Care	200156500A	Hancock Memorial Hospital
Goodland Clinic	200060030A	Iroquois Memorial Hospital (IL)
Kentland Clinic	200133940A	Iroquois Memorial Hospital (IL)

TABLE FQHC-3: List of RHC Providers, Freestanding

Name	Medicaid Number
A N Damodaran, MD Inc.	200171580
American Health Network Family	200256220
American Health Network Family Practice	200127640
Brazil Family Medicine, LLC	200300810
Brook Health Centre	100187080
Cass County Medical Center	200099180 B
Clay City Center for Family Medicine	100079350
Community Medical Services - De Motte	200028250
Community Rural Health Clinic	200261130
Crawford County Family Healthcare	200122740
Cullen Medical Professional	200492170
Dale Family Practice	200282080
Daryl L. Hershberger (Redi-Care, Inc.)	200108370
Daviess Community Hospital Medical Clinic	100270240
Deaconess Medical Group-Petersburg	200139490
Family Health Services	100216100
Fowler Medical Center	200085460
Hometown Healthcare	200133950
James D. Kozarek MD	200140320
Joanne Guttman MD	200109760
John A. Egli, MD, PC	200356420
Kenneth D. Watkins MD	200399280
Knox Family Medical Center	200255890
Knox Family Practice, Inc.	200020860
Martin County Health Center	200298610
Monticello Medical Center	200099180
Nashville Family Medicine	200139770
Nashville Hometown Healthcare	200133950
Nebraska Family Care	200169150
New Castle Pediatrics, P.C.	100134640
North Daviess Medical Clinic	200152680
Oakland City Family Practice	200176150
Owen County Hometown Health Care	100433840
Patoka Family Health Care Center	200164670
Petersburg Family Medicine	200048850K
Petersburg Medical Clinic	200042020
Raymond G. Petrie, MD	200086810

Name	Medicaid Number
Ridge Medical Center	200062690
Robert E. Judge MD	200171050
Royal Center Family Practice	200003920D
Shoals Health Center	200298610
South Central Community Health Care	200257560
Southwest Health Center	100155170
St. Meinrad Archabbey Health Services	200033970
Sullivan Family Practice, LLC	200015680
Switzerland County Nurse Managed Clinic	200254390
Thomas L. Miller MD	200185720
Thoroughcare PC	200241560
Wheatfield Clinic	200301560G
Winslow Medical Center	200505250
Worthington Family Medicine	200153250

MANAGED CARE ORGANIZATION NAME:

FQHC/RHC PROVIDER NAME:

Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NUMBER:

Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER:

Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD:

Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD:

Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD:

Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Package A/B (Fee-For-Service and Capitation)	January	February	March	April	May	June	July	August	September	October	November	December
Total Dollars Paid For Fee-For-Service Claims												
Total Dollars Paid For Quality Incentives												
Total Dollars Paid As Capitation Payments												
Total Dollars Paid As Administrative Fees												

For each item, insert the total dollars paid for Package A/B in $xxx,xxx format in each month of the reporting period.

Package C (Fee-For-Service and Capitation)	January	February	March	April	May	June	July	August	September	October	November	December
Total Dollars Paid For Fee-For-Service Claims												
Total Dollars Paid For Quality Incentives												
Total Dollars Paid As Capitation Payments												
Total Dollars Paid As Administrative Fees												

For each item, insert the total dollars paid for Package C in $xxx,xxx format in each month of the reporting period.

MANAGED CARE ORGANIZATION NAME:

FQHC/RHC PROVIDER NAME:

Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NUMBER:

Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER:

Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD:

Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD:

Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD:

Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Member	Member	Member	Claim	Claim	Date of	Date				Billed	Paid	Place of	Procedure	Diagnosis	Diagnosis	Diagnosis	Provider	Provider	Provider

Consecutively number each member listed beginning with number 1.

Insert the member's first name.

Insert the member's last name.

Insert the member's Medicaid recipient identification number (RID).

Insert the claim number.

Insert the numeric detail line number of the claim.

Insert the date of service of the claim in MM/DD/YYYY format.

Insert the date the claim was paid in MM/DD/YYYY format.

Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.

Insert the billed amount from the detail line number of the claim.

Insert the paid amount of the detail line number of the claim.

Insert the procedure code for the detail line number of the claim.

Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.

Insert the primary diagnosis code as indicated on the claim detail line number of the claim.

If applicable, insert additional secondary diagnosis codes.

Insert the rendering provider's first name.

Insert the rendering provider's last name.

Insert the IHCP provider number of the rendering provider.

MANAGED CARE ORGANIZATION NAME:

FQHC/RHC PROVIDER NAME: Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NUMBER: Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER: Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD: Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD: Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD: Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Item	Member First	Member Last	Member Identification Number	Claim N	Claim Number etail Line	Date of Service	Date Paid	EX1	EX2	EX3	Billed Amount	Paid A	Place of Service	Procedure Code	Diagnosis Code	Diagnosis	Diagnosis Code 3	Provider First Name	Provider Last Name	Provider Number
Consecutively number each member listed beginning with number 1.	Insert the member's first name.	Insert the member's last name.	Insert the member's Medicaid recipient identification number (RID).	Insert the claim number.	Insert the numeric detail line number of the claim.	Insert the date of service of the claim in MM/DD/YYYY format.	Insert the date the claim was paid in MM/DD/YYYY format.			Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.	Insert the billed amount from the detail line number of the claim.		Insert the paid amount of the detail line number of the claim.	Insert the procedure code for the detail line number of the claim.	Insert the primary diagnosis code as indicated on the claim detail line number of the claim.	Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.	If applicable, insert additional secondary diagnosis codes.	Insert the IHCP provider number of the rendering provider.	Insert the rendering provider's first name.	Insert the rendering provider's last name.

MANAGED CARE ORGANIZATION NAME:

Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NAME:

FQHC/RHC PROVIDER NUMBER:

Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER:

Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD:

Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD:

Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD:

Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Insert the procedure code for the detail line number of the claim.

Insert the primary diagnosis code as indicated on the claim detail line number of the claim.

Insert the rendering provider's last name.

If applicable, insert additional secondary diagnosis codes.

Insert the rendering provider's first name.

Item	Member First	Member Last Name	Member Identification	Claim Number	Claim Number Line	Date of Service	Date Paid	EX1	EX2	EX3	Billed Amount	Paid Amount	Place of Service	Procedure Code	Diagnosis Code 1	Diagnosis	Diagnosis Code 3	Provider First Name	Provider Last Name	Provider Number

Consecutively number each member listed beginning with number 1.

Insert the member's first name.

Insert the member's last name.

Insert the member's Medicaid recipient identification number (RID).

Insert the claim number.

Insert the numeric detail line number of the claim.

Insert the date of service of the claim in MM/DD/YYYY format.

Insert the date the claim was paid in MM/DD/YYYY format.

Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.

Insert the billed amount from the detail line number of the claim.

Insert the paid amount of the detail line number of the claim.

Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.

Insert the IHCP provider number of the rendering provider.

MANAGED CARE ORGANIZATION NAME:

Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NAME:

FQHC/RHC PROVIDER NUMBER:

Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER:

Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD:

Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD:

Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD:

Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Item	Member First Name	Member Last Name	Member Identification Number	Claim Number	Claim Number Line	Date of Service	Date Paid	EX1	EX2	EX3	Billed Amount	Paid Amount	Place of Service	Procedure Code	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Provider	Provider Last	Provider Number
Consecutively number each member listed beginning with number 1.	Insert the member's first name.	Insert the member's last name.	Insert the member's Medicaid recipient identification number (RID).	Insert the claim number.	Insert the numeric detail line number of the claim.	Insert the date of service of the claim in MM/DD/YYYY format.	Insert the date the claim was paid in MM/DD/YYYY format.	Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.	Insert the billed amount from the detail line number of the claim.	Insert the paid amount of the detail line number of the claim.	Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.	Insert the IHCP provider number of the rendering provider.							

Insert the procedure code for the detail line number of the claim.

Insert the primary diagnosis code as indicated on the claim detail line number of the claim.

Insert the rendering provider's first name.

If applicable, insert additional secondary diagnosis codes.

Insert the rendering provider's last name.

MANAGED CARE ORGANIZATION NAME:

FQHC/RHC PROVIDER NAME:

Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NUMBER:

Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER:

Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD:

Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD:

Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD:

Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Package A/B (Fee-For-Service and Capitation)	January	February	March	April	May	June
Total Dollars Paid For Fee-For-Service Claims						
Total Dollars Paid For Quality Incentives						
Total Dollars Paid As Capitation Payments						
Total Dollars Paid As Administrative Fees						

For each item, insert the total dollars paid for Package A/B in $xxx,xxx format in each month of the reporting period.

Package C (Fee-For-Service and Capitation)	January	February	March	April	May	June
Total Dollars Paid For Fee-For-Service Claims						
Total Dollars Paid For Quality Incentives						
Total Dollars Paid As Capitation Payments						
Total Dollars Paid As Administrative Fees						

For each item, insert the total dollars paid for Package C in $xxx,xxx format in each month of the reporting period.

MANAGED CARE ORGANIZATION NAME:

Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NAME:

FQHC/RHC PROVIDER NUMBER:

Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER:

Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD:

Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD:

Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD:

Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Insert the procedure code for the detail line number of the claim.

Insert the primary diagnosis code as indicated on the claim detail line number of the claim.

If applicable, insert additional secondary diagnosis codes.

Insert the rendering provider's first name.

Insert the rendering provider's last name.

Item	Member First Name	Member Last Name	Member Identification Number	Claim Number	Date of Service	Date Paid	Billed	Paid	Place of Service	Procedure Code	Diagnosis Code	Diagnosis Code 2	Diagnosis Code 3	Provider First Name	Provider Last Name	Provider Number
Consecutively number each member listed beginning with number 1.	Insert the member's first name.	Insert the member's last name.	Insert the member's Medicaid recipient identification number (RID).	Insert the claim number.	Insert the numeric detail line number of the claim.	Insert the date of service of the claim in MM/DD/YYYY format.	Insert the date the claim was paid in MM/DD/YYYY format.	Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.	Insert the billed amount from the detail line number of the claim.	Insert the paid amount of the detail line number of the claim.	Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.				Insert the IHCP provider number of the rendering provider.	

MANAGED CARE ORGANIZATION NAME: Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NAME:

FQHC/RHC PROVIDER NUMBER: Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER: Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD: Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD: Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD: Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Item	Member First Name	Member Last Name	Member Identification Number	Claim Number	Claim Detail	Date of Service	Date Paid	EX1	EX2	EX3	Billed Amount	Paid Amount	Place of Service Code	Procedure Code	Diagnosis	Diagnosis Code 2	Diagnosis Code 3	Provider First Name	Provider Last Name	Provider Number
Consecutively number each member listed beginning with number 1.	Insert the member's first name.	Insert the member's last name.	Insert the member's Medicaid recipient identification number (RID).	Insert the claim number.	Insert the numeric detail line number of the claim.	Insert the date of service of the claim in MM/DD/YYYY format.	Insert the date the claim was paid in MM/DD/YYYY format.	Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.	Insert the billed amount from the detail line number of the claim.	Insert the paid amount of the detail line number of the claim.	Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.	Insert the procedure code for the detail line number of the claim.	Insert the primary diagnosis code as indicated on the claim detail line number of the claim.	If applicable, insert additional secondary diagnosis codes.	Insert the IHCP provider number of the rendering provider.	Insert the rendering provider's first name.	Insert the rendering provider's last			

MANAGED CARE ORGANIZATION NAME:

FQHC/RHC PROVIDER NAME: Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NUMBER: Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER: Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD: Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD: Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD: Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Item	Member First Name	Member Last Name	Member Identification Number	Claim Number	Claim Number	Date of Service	Date Paid	EX1	EX2	EX3	Billed Amount	Paid Amount	Place of Service	Procedure	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Provider First Name	Provider Last Name	Provider Number
Consecutively number each member listed beginning with number 1.	Insert the member's first name.	Insert the member's last name.	Insert the member's Medicaid recipient identification number (RID).	Insert the claim number.	Insert the numeric detail line number of the claim.	Insert the date of service of the claim in MM/DD/YYYY format.	Insert the date the claim was paid in MM/DD/YYYY format.	Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.	Insert the billed amount from the detail line number of the claim.	Insert the paid amount of the detail line number of the claim.	Insert the procedure code for the detail line number of the claim.	Insert the primary diagnosis code as indicated on the claim detail line number of the claim.	Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.	If applicable, insert additional secondary diagnosis codes.	Insert the rendering provider's first name.	Insert the rendering provider's last name.	Insert the IHCP provider number of the rendering provider.			

MANAGED CARE ORGANIZATION NAME:

FQHC/RHC PROVIDER NAME: Insert the name of the FQHC/RHC on which the MCO is reporting.

FQHC/RHC PROVIDER NUMBER: Insert the Medicaid identification number that corresponds to the FQHC/RHC provider.

CONTRACT OR NON-CONTRACT PROVIDER: Enter "YES" or "NO" to indicate whether the provider is contracted with the MCO.

BEGINNING INCURRED DATE OF REPORTING PERIOD: Insert the beginning date of the reporting period. The reporting period should be based on the dates of service "incurred" during the requested specified provider. Enter in MM/DD/YYYY format.

ENDING INCURRED DATE OF REPORTING PERIOD: Insert the ending date of the reporting period. The reporting period should be based on the dates of service "incurred" by the requested specified provider. Enter in MM/DD/YYYY format.

PAID DATE PERIOD: Insert the paid date period for the above beginning and ending reporting period. Enter in MM/DD/YYYY format.

Item	Member First Name	Member Last Name	Member Identification Number	Claim Number	Claim Detail Line	Date of Service	Date Paid	EX1	EX2	EX3	Billed Amount	Paid Amount	Place of Service	Procedure	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Provider First Name	Provider Last Name	Provider Number
Consecutively number each member listed beginning with number 1.	Insert the member's first name.	Insert the member's last name.	Insert the member's Medicaid recipient identification number (RID).	Insert the claim number.	Insert the numeric detail line number of the claim.	Insert the date of service of the claim in MM/DD/YYYY format.	Insert the date the claim was paid in MM/DD/YYYY format.				Insert the explanation of the benefits, using EX2 and EX3 for more than one benefit description.		Insert the billed amount from the detail line number of the claim.	Insert the paid amount of the detail line number of the claim.	Insert the procedure code for the detail line number of the claim.	Insert the appropriate code from the code descriptions sheet; if "Other, identify", limit description to 25 alpha/numeric characters.	Insert the primary diagnosis code as indicated on the claim detail line number of the claim.	If applicable, insert additional secondary diagnosis codes.	Insert the rendering provider's first name.	Insert the rendering provider's last name.	Insert the IHCP provider number of the rendering provider.

List of FQHC Providers

Name	Provider Number(s)
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Edinburgh/Trafalgar Family Health Center	200127470
HealthNet	100117700
	200013620
Heart City Health Center	100097610
Hilltop Community Health Center	200317310
Indiana Health Centers	100071250
Madison County Community Health Center	200271310
Neighborhood Health Clinic	100050750
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Open Door BMH/Health Center	200167970
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Tippecanoe Community Health Clinic	100232630

List of RHC Providers, Provider-based

Name	Medicaid Number	Hospital
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Family Health Center of Union City	200292060B	St. Vincent Randolph Hospital
Family & Occupational Medicine Center-Lynn	200292060A	St. Vincent Randolph Hospital
St. Vincent North Clinic	200307100A	St. Vincent Williamsport Hospital
St. Vincent South Clinic	200307100B	St. Vincent Williamsport Hospital
Royal Center Family Practice	200003920D	Memorial Hospital of Logansport
Knightstown Family Health Care	200156500A	Hancock Memorial Hospital
Goodland Clinic	200060030A	Iroquois Memorial Hospital (IL)
Kentland Clinic	200133940A	Iroquois Memorial Hospital (IL)

(Continued on the next page.)

List of RHC Providers, Freestanding

(Continued from previous page.)

Name	Medicaid Number
A N Damodaran, MD Inc.	200171580
American Health Network Family	200256220
American Health Network Family Practice	200127640
Brazil Family Medicine, LLC	200300810
Brook Health Centre	100187080
Cass County Medical Center	200099180 B
Clay City Center for Family Medicine	100079350
Community Medical Services - De Motte	200028250
Community Rural Health Clinic	200261130
Crawford County Family Healthcare	200122740
Cullen Medical Professional	200492170
Dale Family Practice	200282080
Daryl L. Hershberger (Redi-Care, Inc.)	200108370
Daviess Community Hospital Medical Clinic	100270240
Deaconess Medical Group-Petersburg	200139490
Family Health Services	100216100
Fowler Medical Center	200085460
Hometown Healthcare	200133950
James D. Kozarek MD	200140320
Joanne Guttman MD	200109760
John A. Egli, MD, PC	200356420
Kenneth D. Watkins MD	200399280
Knox Family Medical Center	200255890
Knox Family Practice, Inc.	200020860
Martin County Health Center	200298610
Monticello Medical Center	200099180
Nashville Family Medicine	200139770
Nashville Hometown Healthcare	200133950
Nebraska Family Care	200169150
New Castle Pediatrics, P.C.	100134640
North Daviess Medical Clinic	200152680
Oakland City Family Practice	200176150
Owen County Hometown Health Care	100433840
Patoka Family Health Care Center	200164670

(Continued on the next page.)

List of RHC Providers, Freestanding

(Continued from the previous page.)

Name	Medicaid Number
Petersburg Family Medicine	200048850K
Petersburg Medical Clinic	200042020
Raymond G. Petrie, MD	200086810
Ridge Medical Center	200062690
Robert E. Judge MD	200171050
Royal Center Family Practice	200003920D
Shoals Health Center	200298610
South Central Community Health Care	200257560
Southwest Health Center	100155170
St. Meinrad Archabbey Health Services	200033970
Sullivan Family Practice, LLC	200015680
Switzerland County Nurse Managed Clinic	200254390
Thomas L. Miller MD	200185720
Thoroughcare PC	200241560
Wheatfield Clinic	200301560G
Winslow Medical Center	200505250
Worthington Family Medicine	200153250

Place of Service Codes

11	Ambulance
24	Ambulatory Surgical Center
25	Birthing Center
23	Emergency Room-Hospital
50	Federally Qualified Health Center
12	Home
21	Inpatient Hospital
81	Laboratory
32	Nursing Facility
11	Office
99	Other, identify
22	Outpatient Hospital
61	Rehabilitation Facility-Inpatient
62	Rehabilitation Facility-Outpatient
72	Rural Health Clinic
31	Skilled Nursing Facility
20	Urgent Care Facility

General Report Description	
AN-DUR Annual Single Source Prior Authorization Drug Listing	
Purpose	Document and review the health plan's drug lists, restrictions, prior authorizations and monitor member grievances relative to drug utilization.
Required Submission Type	Excel workbook
Comments/ Recommendations	These are annual reports. The MCO must submit the reports to the monitoring contractor and OMPP by March 1st. OMPP will send the MCO's DUR reports to the Drug Utilization Review (DUR) Board. There are five Excel templates in the workbook: AN-DUR-1: PDL Comparison of Select Therapeutic Classes, Open Access With No Restrictions AN-DUR-2: PDL Comparison of Select Therapeutic Classes, Clinical Edits With Rationale AN-DUR-3: Number of Prior Authorizations By Drug AN-DUR-4: Pharmacy Prior Authorizations AN-DUR-5: Pharmacy-related Grievances OMPP will submit the Hoosier Healthwise provider satisfaction survey results (especially those questions and responses related to pharmacy benefits) to the DUR when results become available.
Performance Measures	OMPP and the DUR have not indicated specific performance measures for these reports at this time.
AN-DUR Data Elements	
1. All Data Elements For All Worksheets	
Qualifications/ Definitions	Consistent with the ACS FFS notation on PDL comparison, all brand name drugs must be noted in all upper case script (e.g., ADDERALL XL). Generic drug names must be noted in all lower case script (e.g., dextroamphetimine). The MCO may increase lines in the worksheets to accommodate its complete listing of drugs. (Continued on the next page.)

Qualifications/ Definitions (Continued)	(Continued from the previous page.) AN-DUR-1: Lists the PDL drugs that are subject to no restrictions, i.e., open access. AN-DUR-2: Lists the number and type of drugs that are subject to a restriction and the rationale for the restriction using clinical edit codes. AN-DUR-3: Reviews the number of requests for prior authorization, the number approved and the number denied. This report should include all prior authorization requests for drugs but does not include provide cited Medical Necessity, as OMPP is using the strictest interpretation of prior authorization. Due to re-directs and/or substitution data measuring issues, this report should include only approved or denied drugs. (NOTE: Denied drugs are those that generate a denial notice.) AN-DUR-4: Reviews the number of single source drugs requiring prior authorization and the rationale for the prior authorization requirement using clinical edit codes. This should include only the drugs on the MCO's PDL requiring prior authorization. AN-DUR-5: Requests detailed information and total numbers for all member grievances related to pharmacy for the calendar year by quarter. Clinical edits should be noted as one of the following restriction codes: • Prior Authorization = PA • Quantity Level Limits = QLL • Step Therapy = ST • Age Limit = AGE • Concurrent Therapy = CT
Formula	None

AN-DUR-1: PDL Comparison of Select Therapeutic Classes, Open Access With No Restrictions

MCO Name_____

Insert the MCO's name.

Reporting Period_____

Insert the calendar year to which the data applies.

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Description
Allergy/Cold	ACETYLCYSTEINE		
	EXPECTORANTS		
	ANTITUSSIVES, NON-NARCOTIC		
	NASAL ANTIHISTAMINE		
	NASAL MAST CELL STABILIZERS AGENTS		
Analgesics	NARCOTICS/NON-NARCOTIC ANALGESICS		
	ANALGESIC/ANTIPYRETICS, SALICYLATES		
	ANALGESIC/ANTIPYRETICS, NON-SALICYLATE		
	SKELETAL MUSCLE RELAXANTS		
Antimicrobials	CEPHALOSPORINS		
	MACROLIDES		
	NITROFURAN DERIVATIVES		
	PENICILLINS		
	TETRACYCLINES		
	ANTIVIRALS		
	ANTIVIRALS, HIV SPECIFIC		
	ANTIFUNGALS		

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Description
Asthma/COPD/ Pulmonary	INHALED CORTICOSTEROIDS		
	INHALED CORTICOSTEROID/LONG ACTING BETA AGONIST COMBINATION		
	LEUKOTRIENE INHIBTORS		
	LONG-ACTING BETA AGONISTS		
	NASAL CORTICOSTEROIDS		
	NON-SEDATING ANTIHISTAMINES		
	SHORT-ACTING BETA AGONISTS		
Cardiovascular	ALPHA ADRENERGIC BLOCKERS		
	BETA ADRENERGIC BLOCKERS		
	ACE INHIBITORS		
	ACE INHIBITORS/DIURETICS		
	ARBS		
	ARBS/DIURETICS		
	CALCIUM CHANNEL BLOCKING AGENTS		
Genitoruniary	BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS		
	URINARY TRACT ANTISPASMODIC/ANTI-INCONTINENCE AGENT		
Diabetes Related	INSULIN		
	ANTIDIABETIC AGENTS		

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Description
Dermatologic	ANTIPSORIATICS AGENTS		
	TOPICAL ANTIFUNGALS		
	TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY STERIOD AGENT		
	TOPICAL ANTINEOPLASTIC & PREMALIGNANT LESION AGENTS		
	TOPICAL IMMUNOSUPPRESSIVE AGENTS		
	TOPICAL ANTI-INFLAMMATORY STEROIDAL		
	TOPICAL ANTIVIRALS		
	TOPICAL ANTIBIOTICS		
	TOPICAL ANTIBIOTICS/ANTI-INFLAMMATORY STEROIDAL		
Gastrointestinal Agents	MISOPROSTOL		
Blood Related Agents	PLATELET AGGREGATION INHIBITORS		
	FIBRIC ACIDS		
	HMG CoA REDUCTASE INHIBITORS		
	HEPARIN AND RELATED PREPARATIONS		
	ORAL ANTICOAGULANTS, COUMARIN TYPE		
	ORAL ANTICOAGULANTS, INDANDIONE TYPE		
	HEMATINICS		
	LEUKOCYTE STIMULANTS		

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Description
Bile Acid Sequestrants	BILE SALT SEQUESTRANTS		
Osteoporosis Agents	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERM), BONE RESORPTION SUPPRESSION AGENTS		
Diuretics	OSMOTIC DIURETICS		
	CARBONIC ANHYDRASE INHIBITORS		
	THIAZIDE AND RELATED DIURETICS		
	POTASSIUM SPARING DIURETICS		
	POTASSIUM SPARING DIURETICS IN COMBINATION		
	LOOP DIURETICS		
CNS Agents**	ANTICONVULSANTS		
	CENTRAL NERVOUS SYSTEM STIMULANTS		
	BARBITURATES		
	SEDATIVE-HYPNOTICS		
	ANTI-ANXIETY DRUGS		
	MOOD STABILIZERS		
	ANTI-PSYCHOTICS TYPICAL		
	ANTI-PSYCHOTICS ATYPICAL		
	SEROTONIN SPECIFIC REUPTAKE INHIBITOR (SSRIS)		
	ANTI-MANIA DRUGS		

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Description
CNS Agents (Continued)**	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)		
	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)		
	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)		
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIB (SEL-NARI)		
	SEROTONIN AND DOPAMINE REUPTAKE INHIBITORS (SDRIS)		
	ANTI-DEPRESSANTS, OTHER		
	URECHOLINE, BETHANECHOL		
	ARICEPT, COGNEX, MESTINON, EXELON, REMINYL		
	BENZTROPINE, TRIHEXYPHENIDYL, AKINETON, KEMADRIN		
Antiemetic/ Antivertigo	COMPAZINE, PROCHLORPERAZINE, PROMETHAZINE, MECLIZINE, TRIMETHOBENZAMIDE		
Migraine Medications	CAFERGOT, WIGRAINE, DURADRIN, MIDRIN		

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Description
Obstetric/ Gynecological	ESTROGENIC AGENTS		
	PROGESTATIONAL AGENTS		
	CONTRACEPTIVES, ORAL		
	VAGINAL ANTIFUNGALS		
	VAGINAL ESTROGEN PREPARATIONS		
	VAGINAL ANTIBIOTICS		
Ophthalmic/Otic	EYE ANTI-INFECTIVES (RX ONLY)		
	EYE VASOCONSTRICTORS (RX ONLY)		
	EYE IRRIGATIONS		
	MIOTICS/OTHER INTRAOC. PRESSURE REDUCERS		
	EYE ANTIBIOTIC-CORTICOID COMBINATIONS		
	MYDRIATICS		
	EYE ANTIHISTAMINES		
	EYE ANTI-INFLAMMATORY AGENTS		
	OPHTHALMIC MAST CELL STABILIZERS		
	EYE ANTIVIRALS		
	OTIC ANTIBIOTICS		

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Description
Rheumatological+ A121	COLCHICINE, COLCHICINE/PROBENECID		
	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE		
	ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR		
	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR		
	ANTI-FLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST		
	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS		
**Note: In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic and "cross indicated" drugs are considered as being on the Fee-For-Service PDL.			
When a brand name drug having a generic equivalent is included in the "Non-Preferred Drug List" listing, please note that the generic equivalents for the brand name drug are considered as preferred medications on the Fee-for-Service PDL, unless otherwise specified.			
Prior authorization for Brand Medically Necessary is not required for the drugs specifically exempted by the DUR Board from a prior authorization for Brand Medically Necessary requirement for the Fee-for-Service PDL (i.e., those drugs being what are typically referred to as "narrow therapeutic index").			

AN-DUR-2: PDL Comparison of Select Therapeutic Classes, Clinical Edits With Rationale

MCO Name_____

Insert the MCO's name.

Reporting Period_____

Insert the calendar year to which the data applies.

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Clinical Edits	Rationale
Allergy/Cold	ACETYLCYSTEINE			
	EXPECTORANTS			
	ANTITUSSIVES, NON-NARCOTIC			
	NASAL ANTIHISTAMINE			
	NASAL MAST CELL STABILIZERS AGENTS			
Analgesics	NARCOTICS/NON-NARCOTIC ANALGESICS			
	ANALGESIC/ANTIPYRETICS, SALICYLATES			
	ANALGESIC/ANTIPYRETICS, NON-SALICYLATE			
	SKELETAL MUSCLE RELAXANTS			
Antimicrobials	CEPHALOSPORINS			
	FLUOROQUINOLONES			
	MACROLIDES			
	NITROFURAN DERIVATIVES			
	PENICILLINS			
	TETRACYCLINES			
	ANTIVIRALS			
	ANTIVIRALS, HIV SPECIFIC			
	ANTIVIRALS, MONOCLONAL ANTIBODIES			
	ANTIFUNGALS			

Use the following Clinical Edits:
PA - Prior Authorization
QLL - Quantity Level Limits
ST - Step Therapy
AGE - Age Limit
CT - Concurrent Therapy

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Clinical Edits	Rationale
Asthma/COPD/ Pulmonary	INHALED CORTICOSTEROIDS			
	INHALED CORTICOSTEROID/LONG ACTING BETA AGONIST COMBINATION			
	LEUKOTRIENE INHIBTORS			
	LONG-ACTING BETA AGONISTS			
	NASAL CORTICOSTEROIDS			
	NON-SEDATING ANTIHISTAMINES			
	SHORT-ACTING BETA AGONISTS			
Cardiovascular	ALPHA ADRENERGIC BLOCKERS			
	BETA ADRENERGIC BLOCKERS			
	ACE INHIBITORS			
	ACE INHIBITOR/CALCIUM CHANNEL BLOCKER COMBINATION			
	ACE INHIBITORS/DIURETICS			
	ANGIOTENSIN RECEPTOR ANTAGONIST			
	ARBS/DIURETICS			
	CALCIUM CHANNEL BLOCKING AGENTS			
Genitoruniary	BENIGN PROSTATIC HYPERTROPHY/MICTURITION AGENTS			
	URINARY TRACT ANTISPASMODIC/ANTI-INCONTINENCE AGENT			
Diabetes Related	HYPOGLYCEMIC/INSULIN RESPONSE ENHANCER (N-S)			
	INSULIN			
	ANTIDIABETIC AGENTS			

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Clinical Edits	Rationale
Dermatologic	VITAMIN A DERIVATIVES TOPICAL ACNE AGENTS			
	VITAMIN A DERIVATIVES SYSTEMIC			
	ANTIPSORIATICS AGENTS			
	TOPICAL ANTIFUNGALS			
	TOPICAL ANTIFUNGAL/ANTI-INFLAMMATORY,STERIOD AGENT			
	TOPICAL ANTINEOPLASTIC & PREMALIGNANT LESION AGNTS			
	TOPICAL IMMUNOSUPPRESSIVE AGENTS			
	TOPICAL ANTI-INFLAMMATORY STEROIDAL			
	TOPICAL ANTIVIRALS			
	TOPICAL ANTIBIOTICS			
	TOPICAL ANTIBIOTICS/ANTI-INFLAMMATORY, STEROIDAL			
Gastrointestinal Agents	PROTON PUMP INHIBITORS			
	H2RA BLOCKERS			
	ANTI-ULCER/H. PYLORI AGENTS			
	SUCRALFATE			
Blood Related Agents	PLATELET AGGREGATION INHIBITORS			
	FIBRIC ACIDS			
	HMG CoA REDUCTASE INHIBITORS			
	HEPARIN AND RELATED PREPARATIONS			
	ORAL ANTICOAGULANTS, COUMARIN TYPE			
	ORAL ANTICOAGULANTS, INDANDIONE TYPE			
	HEMATINICS			
	LEUKOCYTE STIMULANTS			

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Clinical Edits	Rationale
Bile Acid Sequestrants	BILE SALT SEQUESTRANTS			
Osteoporosis Agents	BONE FORMATION STIMULATING AGENTS			
	SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERM), BONE RESORPTION SUPPRESSION AGENTS			
Diuretics	OSMOTIC DIURETICS			
	CARBONIC ANHYDRASE INHIBITORS			
	THIAZIDE AND RELATED DIURETICS			
	POTASSIUM SPARING DIURETICS			
	POTASSIUM SPARING DIURETICS IN COMBINATION			
	LOOP DIURETICS			
CNS Agents**	ANTICONVULSANTS			
	CENTRAL NERVOUS SYSTEM STIMULANTS			
	BARBITURATES			
	SEDATIVE-HYPNOTICS			
	ANTI-ANXIETY DRUGS			
	MOOD STABILIZERS			
	ANTI-PSYCHOTICS TYPICAL			
	ANTI-PSYCHOTICS ATYPICAL			
	SEROTONIN SPECIFIC REUPTAKE INHIBITOR (SSRIS)			
	ANTI-MANIA DRUGS			
	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)			
	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)			
	SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS)			
	SELECTIVE NOREPINEPHRINE REUPTAKE INHIB (SEL-NARI)			

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Clinical Edits	Rationale
CNS Agents (Continued)**	SEROTONIN AND DOPAMINE REUPTAKE INHIBITORS (SDRIS)			
	ANTI-DEPRESSANTS, OTHER			
	URECHOLINE, BETHANECHOL			
	ARICEPT, COGNEX, MESTINON, EXELON, REMINYL			
	BENZTROPINE, TRIHEXYPHENIDYL, AKINETON, KEMADRIN			
Antiemetic/ Antivertigo	COMPAZINE, PROCHLORPERAZINE, PROMETHAZINE, MECLIZINE, TRIMETHOBENZAMIDE			
	SEROTONIN (5HT-4) PARTIAL AGONIST AGENTS			
Migraine Medications	CAFERGOT, WIGRAINE, DURADRIN, MIDRIN			
	SEROTONIN (5HT-4) PARTIAL AGONIST AGENTS			
Smoking Deterrents	NICOTINE PATCH, NICOTROL NS, NICOTROL INHALER, NICOTINE GUM, COMMIT LOZENGE			
Obstetric/ Gynecological	ESTROGENIC AGENTS			
	PROGESTATIONAL AGENTS			
	CONTRACEPTIVES, ORAL			
	VAGINAL ANTIFUNGALS			
	VAGINAL ESTROGEN PREPARATIONS			
	VAGINAL ANTIBIOTICS			
Ophthalmic/Otic	EYE ANTI-INFECTIVES (RX ONLY)			
	EYE VASOCONSTRICTORS (RX ONLY)			
	EYE IRRIGATIONS			
	MIOTICS/OTHER INTRAOC. PRESSURE REDUCERS			
	EYE ANTIBIOTIC-CORTICOID COMBINATIONS			
	MYDRIATICS			

Categories	Drug Class Name/Description	Drug Name/ Nomenclature	Clinical Edits	Rationale
Ophthalmic/Otic (Continued)	EYE ANTIHISTAMINES			
	EYE ANTI-INFLAMMATORY AGENTS			
	OPHTHALMIC MAST CELL STABILIZERS			
	EYE ANTIVIRALS			
	OTIC ANTIBIOTICS			
Rheumatological	COLCHICINE, COLCHICINE/PROBENECID			
	NSAIDS, CYCLOOXYGENASE INHIBITOR - TYPE			
	ANTI-INFLAMMATORY, PYRIMIDINE SYNTHESIS INHIBITOR			
	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR			
	ANTI-FLAM. INTERLEUKIN-1 RECEPTOR ANTAGONIST			
	ANTI-ARTHRITIC, FOLATE ANTAGONIST AGENTS			
Immunologics and Vaccines	INTERFERONS			
	GROWTH HORMONES			

AN-DUR-3: Number of Prior Authorizations by Drug

MCO Name _____

Insert the MCO's name.

Reporting Period_____

Insert the calendar year to which the data applies.

Number of Prior Authorization Requests	
	TOTAL NUMBER
Total Number Received	0
Total Number Approved	
Total Number Denied	

Name of Drug	Number of Requests	Number Approved	Number Denied
TOTAL:	**0**	**0**	**0**

This includes all Prior Authorization Requests for drugs; does NOT include provider cited Medical Necessity.

This should not include re-directs or denials due to a lack of information; this should represent ONLY those drugs that generate a Denial Notice.

MCO Name _____

Insert the MCO's name.

Reporting Period_____

Insert the calendar year to which the data applies.

	TOTAL NUMBER
Single source medications requiring PA	
Single source medications having QLL	
Single source medications requiring ST	
Single source medications having AGE	
Single source medications having CT	

Single Source Drugs Requiring Prior Authorization	
Drug Name	**Rationale for PA Requirement**

List ONLY those drugs listed on the MCO's PDL as requiring prior authorization.

AN-DUR-5: Pharmacy-related Grievances

MCO Name _____

Insert the MCO's name.

Reporting Period_____

Insert the calendar year to which the data applies.

Enter the total number of pharmacy-related grievances for the calendar year.

Total Calendar Year Pharmacy-related Grievances: _____

Grievance: Verbal or written expression of dissatisfaction for which the member has a reasonable expectation that action will be taken to resolve or reconsider the matter expressed. If a verbal grievance takes less than a business day to resolve, it is considered an inquiry.

Date of Grievance	Date Resolved	Pharmacy Name	Reason for Grievance/ Summary of Actions Taken
		Quarter 1 Total: ____	
		Quarter 2 Total: ____	
		Quarter 3 Total: ____	
		Quarter 4 Total: ____	

For each calendar quarter, enter the total number of pharmacy-related grievances.

Item No.	Report No.	January 2006 Reporting Tasks	Reporting Period	Due Date
1	MO-M1	Member Helpline Performance (New Plans)	December-05	January 16, 2006
2	MO-M2	Member Inquiries (New Plans)	December-05	January 16, 2006
3	MO-M3	Member Grievances (New Plans)	December-05	January 16, 2006
4	MO-M4	Member Appeals (New Plans)	December-05	January 16, 2006
5	MO-P1	Provider Helpline Performance (New Plans)	December-05	January 16, 2006
6	AN-F1	Insurance Premium Notice (On-site monitoring)	2006	January 31, 2006
7	AN-N1	Network Geographic Access Assessment	2006	January 31, 2006
8	AN-N2	Provider Directory	2006	January 31, 2006
9	AN-N3	Subcontractor Compliance Summary Report (On-site	2005	January 31, 2006
10	AN-N4	24-Hour Availability Audit	2005	January 31, 2006
11	AN-PIP	Physician Incentive Plan (On-site monitoring)	2006	January 31, 2006
12	AN-Q1	HEDIS® Work Plan (Quarterly updates as directed by OMPP)	2005	January 31, 2006
13	AN-Q2	Quality Management and Improvement Work Plan Activities Summary	2005	January 31, 2006
14	AN-Q2A	Quality Management and Improvement Program Activities Detail (Executive Summary only)	2005	January 31, 2006
15	AN-Q8	Program Integrity Activities Summary	2005	January 31, 2006
16	MO-M1	Member Helpline Performance (Legacy Plans)	Q4-05	January 31, 2006
17	MO-M2	Member Inquiries (Legacy Plans)	Q4-05	January 31, 2006
18	MO-M3	Member Grievances (Legacy Plans)	Q4-05	January 31, 2006
19	MO-M4	Member Appeals (Legacy Plans)	Q4-05	January 31, 2006
20	MO-P1	Provider Helpline Performance (Legacy Plans)	Q4-05	January 31, 2006
21	QR-N5	Promotional, Educational, Outreach and Incentive Materials Inventory and Distribution (On-site monitoring)	Q4-05	January 31, 2006
22	QR-P1	Informal Provider Claims Disputes	Q4-05	January 31, 2006
23	QR-P2	Formal Provider Claims Disputes	Q4-05	January 31, 2006
24	QR-P3	Binding Arbitration	Q4-05	January 31, 2006
25	QR-Q1	Quality Management and Improvement Committee Meeting Minutes (On-site monitoring)	Q4-05	January 31, 2006
26	QR-S1	Claims Processing Summary	Q4-05	January 31, 2006
27	QR-S2	Adjudicated Claims Inventory Summary	Q4-05	January 31, 2006
28	QR-S3	Top Ten Claims Denial Reasons	Q4-05	January 31, 2006
29	AN-Q3	HEDIS® Baseline Assessment Tool (BAT)(formerly AN-Q5)	2005	January 31, 2006

Item No.	Report No.	February 2006 Reporting Tasks	Reporting Period	Due Date
30	MO-M1	Member Helpline Performance (New Plans)	January-06	February 15, 2006
31	MO-M2	Member Grievances (New Plans)	January-06	February 15, 2006
32	MO-M3	Member Appeals (New Plans)	January-06	February 15, 2006
33	MO-P1	Provider Helpline Performance (New Plans)	January-06	February 15, 2006
Item No.	**Report No.**	**March 2006 Reporting Tasks**	**Reporting Period**	**Due Date**
34	AN-Q1	Quality Management and Improvement Work Plan	2006	March 1, 2006
35	AN-DUR	Annual Single Source Prior Authorization Drug Listing (DUR) Reports	2005	March 1, 2006
36	QR-F1	Indicators of Financial Stability	Q4-05	March 1, 2006
37	QR-IDOI	Indiana Department of Insurance (IDOI) Filing	Q4-05	March 1, 2006
38	MO-M1	Member Helpline Performance (New Plans)	February-06	March 15, 2006
39	MO-M2	Member Grievances (New Plans)	February-06	March 15, 2006
40	MO-M3	Member Appeals (New Plans)	February-06	March 15, 2006
41	MO-P1	Provider Helpline Performance (New Plans)	February-06	March 15, 2006
42	AN-Q5	Asthma Common Measures (Legacy Plans Only)	CY 2004	March 15, 2006
Item No.	**Report No.**	**April 2006 Reporting Tasks**	**Reporting Period**	**Due Date**
43	MO-M1	Member Helpline Performance (New Plans)	March-06	April 17, 2006
44	MO-M2	Member Grievances (New Plans)	March-06	April 17, 2006
45	MO-M3	Member Appeals (New Plans)	March-06	April 17, 2006
46	MO-P1	Provider Helpline Performance (New Plans)	March-06	April 17, 2006

Item No.	Report No.	May 2006 Reporting Tasks	Reporting Period	Due Date
47	AN-Q1	HEDIS® Work Plan (Quarterly updates as directed by OMPP)	2005	May 1, 2006
48	MO-M1	Member Helpline Performance (Legacy Plans)	Q1-06	May 1, 2006
49	MO-M2	Member Grievances (Legacy Plans)	Q1-06	May 1, 2006
50	MO-M3	Member Appeals (Legacy Plans)	Q1-06	May 1, 2006
51	MO-P1	Provider Helpline Performance (Legacy Plans)	Q1-06	May 1, 2006
52	QR-M1	FSSA Hearings and Appeals (Ad Hoc)	Q1-06	May 1, 2006
53	QR-N1	Promotional, Educational, Outreach and Incentive Materials Inventory and Distribution (On-site monitoring)	Q1-06	May 1, 2006
54	QR-P1	Informal Provider Claims Disputes	Q1-06	May 1, 2006
55	QR-P2	Formal Provider Claims Disputes	Q1-06	May 1, 2006
56	QR-P3	Binding Arbitration (Ad Hoc)	Q1-06	May 1, 2006
57	QR-Q1	Quality Management and Improvement Committee Meeting Minutes (On-site monitoring)	Q1-06	May 1, 2006
58	QR-Q2	Medical Necessity Review Log (On-site monitoring)	Q1-06	May 1, 2006
59	QR-S1	Claims Processing Summary	Q1-06	May 1, 2006
60	QR-S2	Adjudicated Claims Inventory Summary	Q1-06	May 1, 2006
61	QR-S3	Top Ten Claims Denial Reasons	Q1-06	May 1, 2006
62	MO-M1	Member Helpline Performance (New Plans)	April-06	May 15, 2006
63	MO-M2	Member Grievances (New Plans)	April-06	May 15, 2006
64	MO-M3	Member Appeals (New Plans)	April-06	May 15, 2006
65	MO-P1	Provider Helpline Performance (New Plans)	April-06	May 15, 2006
66	QR-F1	Indicators of Financial Stability	Q1-06	May 15, 2006
67	QR-IDOI	Indiana Department of Insurance (IDOI) Filing	Q1-06	May 15, 2006
68	SA-CRCS-1	Capitation Rate Calculation Sheet	Jul-Dec 05	May 15, 2006
69	SA-CRCS-2	Maternity Capitation Rate Calculation Sheet	Jul-Dec 05	May 15, 2006
70	SA-F1	Stop Loss	Jul-Dec 05	May 15, 2006

Item No.	Report No.	June 2006 Reporting Tasks	Reporting Period	Due Date
71	MO-M1	Member Helpline Performance (New Plans)	May-06	June 15, 2006
72	MO-M2	Member Grievances (New Plans)	May-06	June 15, 2006
73	MO-M3	Member Appeals (New Plans)	May-06	June 15, 2006
74	MO-P1	Provider Helpline Performance (New Plans)	May-06	June 15, 2006
75	AN-Q2	HEDIS® Data Submission Tool (DST)	2005	June 15, 2006
76	AN-Q5	Asthma Common Measures (All MCOs)	Q1-05 and Q4-05	June 15, 2006
Item No.	Report No.	July 2006 Reporting Tasks	Reporting Period	Due Date
77	AN-M1	Summary of Consumer Assessment of Health Plans Survey (CAHPS)	2005	July 31, 2006
78	MO-M1	Member Helpline Performance (New Plans)	June-06	July 17, 2006
79	MO-M2	Member Grievances (New Plans)	June-06	July 17, 2006
80	MO-M3	Member Appeals (New Plans)	June-06	July 17, 2006
81	MO-P1	Provider Helpline Performance (New Plans)	June-06	July 17, 2006
82	MO-M1	Member Helpline Performance (Legacy Plans)	Q2-06	July 31, 2006
83	MO-M2	Member Grievances (Legacy Plans)	Q2-06	July 31, 2006
84	MO-M3	Member Appeals (Legacy Plans)	Q2-06	July 31, 2006
85	MO-P1	Provider Helpline Performance (Legacy Plans)	Q2-06	July 31, 2006
86	QR-M1	FSSA Hearings and Appeals (Ad Hoc)	Q2-06	July 31, 2006
87	QR-N1	Promotional, Educational, Outreach and Incentive Materials	Q2-06	July 31, 2006
88	QR-P1	Informal Provider Claims Disputes	Q2-06	July 31, 2006
89	QR-P2	Formal Provider Claims Disputes	Q2-06	July 31, 2006
90	QR-P3	Binding Arbitration (Ad Hoc)	Q2-06	July 31, 2006
91	QR-Q1	Quality Management and Improvement Committee Meeting	Q2-06	July 31, 2006
92	QR-Q2	Medical Necessity Review Log (On-site monitoring)	Q2-06	July 31, 2006
93	QR-S1	Claims Processing Summary	Q2-06	July 31, 2006
94	QR-S2	Adjudicated Claims Inventory Summary	Q2-06	July 31, 2006
95	QR-S3	Top Ten Claims Denial Reasons	Q2-06	July 31, 2006

Item No.	Report No.	August 2006 Reporting Tasks	Reporting Period	Due Date
96	AN-Q4	HEDIS Compliance Auditor's Final Report	2005	August 1, 2006
97	MO-M1	Member Helpline Performance (New Plans)	July-06	August 15, 2006
98	MO-M2	Member Grievances (New Plans)	July-06	August 15, 2006
99	MO-M3	Member Appeals (New Plans)	July-06	August 15, 2006
100	MO-P1	Provider Helpline Performance (New Plans)	July-06	August 15, 2006
101	QR-F1	Indicators of Financial Stability	Q2-06	August 15, 2006
102	QR-IDOI	Indiana Department of Insurance (IDOI) Filing	Q2-06	August 15, 2006
103	AN-FQHC	Reimbursement for FQHC and RHC Services	Jan-Dec 05 Jan-Jun 06	August 15, 2006
Item No.	Report No.	September 2006 Reporting Tasks	Reporting Period	Due Date
104	AN-Q1	HEDIS® Work Plan	2006	September 15, 2006
105	MO-M1	Member Helpline Performance (New Plans)	August-06	September 15, 2006
106	MO-M2	Member Grievances (New Plans)	August-06	September 15, 2006
107	MO-M3	Member Appeals (New Plans)	August-06	September 15, 2006
108	MO-P1	Provider Helpline Performance (New Plans)	August-06	September 15, 2006
109	AN-Q5	Asthma Common Measures (All MCOs)	Q2-05 - Q1-06	September 15, 2006

Item No.	Report No.	October 2006 Reporting Tasks	Reporting Period	Due Date
110	MO-M1	Member Helpline Performance (New Plans)	September-06	October 16, 2006
111	MO-M2	Member Grievances (New Plans)	September-06	October 16, 2006
112	MO-M3	Member Appeals (New Plans)	September-06	October 16, 2006
113	MO-P1	Provider Helpline Performance (New Plans)	September-06	October 16, 2006
114	AN-Q1	HEDIS® Work Plan (Quarterly update as directed by OMPP)	2006	October 31, 2006
115	MO-M1	Member Helpline Performance (Legacy Plans)	Q3-06	October 31, 2006
116	MO-M2	Member Grievances (Legacy Plans)	Q3-06	October 31, 2006
117	MO-M3	Member Appeals (Legacy Plans)	Q3-06	October 31, 2006
118	MO-P1	Provider Helpline Performance (Legacy Plans)	Q3-06	October 31, 2006
119	QR-M1	FSSA Hearings and Appeals (Ad Hoc)	Q3-06	October 31, 2006
120	QR-N1	Promotional, Educational, Outreach and Incentive Materials Inventory and Distribution (On-site monitoring)	Q3-06	October 31, 2006
121	QR-P1	Informal Provider Claims Disputes	Q3-06	October 31, 2006
122	QR-P2	Formal Provider Claims Disputes	Q3-06	October 31, 2006
123	QR-P3	Binding Arbitration (Ad Hoc)	Q3-06	October 31, 2006
124	QR-Q1	Quality Management and Improvement Committee Meeting Minutes (On-site monitoring)	Q3-06	October 31, 2006
125	QR-Q2	Medical Necessity Review Log (On-site monitoring)	Q3-06	October 31, 2006
126	QR-S1	Claims Processing Summary	Q3-06	October 31, 2006
127	QR-S2	Adjudicated Claims Inventory Summary	Q3-06	October 31, 2006
128	QR-S3	Top Ten Claims Denial Reasons	Q3-06	October 31, 2006

Item No.	Report No.	November 2006 Reporting Tasks	Reporting Period	Due Date
129	SA-CRCS-1	Capitation Rate Calculation Sheet	Jan-Jun 06	November 15, 2006
130	SA-CRCS-2	Maternity Capitation Rate Calculation Sheet	Jan-Jun 06	November 15, 2006
131	SA-F1	Stop Loss	Jan-Jun 06	November 15, 2006
132	QR-F1	Indicators of Financial Stability	Q3-06	November 15, 2006
133	QR-IDOI	Indiana Department of Insurance (IDOI) Filing	Q3-06	November 15, 2006
134	MO-M1	Member Helpline Performance (New Plans)	October-06	November 15, 2006
135	MO-M2	Member Grievances (New Plans)	October-06	November 15, 2006
136	MO-M3	Member Appeals (New Plans)	October-06	November 15, 2006
137	MO-P1	Provider Helpline Performance (New Plans)	October-06	November 15, 2006
Item No.	Report No.	December 2006 Reporting Tasks	Reporting Period	Due Date
138	MO-M1	Member Helpline Performance (New Plans)	November-06	December 15, 2006
139	MO-M2	Member Grievances (New Plans)	November-06	December 15, 2006
140	MO-M3	Member Appeals (New Plans)	November-06	December 15, 2006
141	MO-P1	Provider Helpline Performance (New Plans)	November-06	December 15, 2006
142	AN-Q5	Asthma Common Measures (All MCOs)	Q3-05 - Q2-06	December 15, 2006

Item No.	Report No.	January 2007 Reporting Tasks	Reporting Period	Due Date
143	MO-M1	Member Helpline Performance (New Plans)	December-06	January 15, 2007
144	MO-M2	Member Grievances (New Plans)	December-06	January 15, 2007
145	MO-M3	Member Appeals (New Plans)	December-06	January 15, 2007
146	MO-P1	Provider Helpline Performance (New Plans)	December-06	January 15, 2007
147	AN-N3	Subcontractor Compliance Summary Report (On-site monitoring)	2006	January 31, 2007
148	AN-N4	24-Hour Availability Audit	2006	January 31, 2007
149	AN-Q1	HEDIS® Work Plan (Quarterly update as directed by OMPP)	2006	January 31, 2007
150	AN-Q3	HEDIS® Baseline Assessment Tool (BAT)	2006	January 31, 2007
151	QR-Q1	Quality Management and Improvement Committee Meeting Minutes (On-site monitoring)	Q4-06	January 31, 2007
152	QR-Q2	Medical Necessity Review Log (On-site monitoring)	Q4-06	January 31, 2007
153	QR-S1	Claims Processing Summary	Q4-06	January 31, 2007
154	QR-S2	Adjudicated Claims Inventory Summary	Q4-06	January 31, 2007
155	QR-S3	Top Ten Claims Denial Reasons	Q4-06	January 31, 2007
156	MO-M1	Member Helpline Performance (Legacy Plans)	Q4-06	January 31, 2007
157	MO-M2	Member Grievances (Legacy Plans)	Q4-06	January 31, 2007
158	MO-M3	Member Appeals (Legacy Plans)	Q4-06	January 31, 2007
159	QR-M1	FSSA Hearings and Appeals (Ad Hoc)	Q4-06	January 31, 2007
160	MO-P1	Provider Helpline Performance (Legacy Plans)	Q4-06	January 31, 2007
161	QR-N1	Promotional, Educational, Outreach and Incentive Materials Inventory and Distribution (On-site monitoring)	Q4-06	January 31, 2007
162	QR-P1	Informal Provider Claims Disputes	Q4-06	January 31, 2007
163	QR-P2	Formal Provider Claims Disputes	Q4-06	January 31, 2007
164	QR-P3	Binding Arbitration (Ad Hoc)	Q4-06	January 31, 2007

Item No.	Report No.	February 2007 Reporting Tasks	Reporting Period	Due Date
		NONE		
Item No.	**Report No.**	**March 2007 Reporting Tasks**	**Reporting Period**	**Due Date**
165	QR-F1	Indicators of Financial Stability	Q4-06	March 1, 2007
166	QR-IDOI	Indiana Department of Insurance (IDOI) Filing	Q4-06	March 1, 2007
167	AN-Q5	Asthma Common Measures (All MCOs)	Q4-05 - Q3-06	March 15, 2007
Item No.	**Report No.**	**April 2007 Reporting Tasks**	**Reporting Period**	**Due Date**
		NONE		
Item No.	**Report No.**	**May 2007 Reporting Tasks**	**Reporting Period**	**Due Date**
168	SA-CRCS-1	Capitation Rate Calculation Sheet	Jul-Dec 06	May 15, 2007
169	SA-CRCS-2	Maternity Capitation Rate Calculation Sheet	Jul-Dec 06	May 15, 2007
170	SA-F1	Stop Loss	Jul-Dec 06	May 15, 2007
Item No.	**Report No.**	**June 2007 Reporting Tasks**	**Reporting Period**	**Due Date**
171	AN-Q2	HEDIS® Data Submission Tool (DST)	2006	June 15, 2007
172	AN-Q5	Asthma Common Measures (All MCOs)	Q1-06 - Q4-06	June 15, 2007
Item No.	**Report No.**	**August 2007 Reporting Tasks**	**Reporting Period**	**Due Date**
173	AN-Q4	HEDIS® Compliance Auditor's Final Report	2006	August 1, 2007
Item No.	**Report No.**	**September 2007 Reporting Tasks**	**Reporting Period**	**Due Date**
174	AN-Q5	Asthma Common Measures (All MCOs)	Q2-06 - Q1-07	September 15, 2007